
BU
R.N
December • 194

Betty's rubs used to make patients sore—
Her hands were like unrefined ore,
Till an intern one day
Sent some Pacquins her way;
Now the patients are screaming for more!

● **Pacquins Hand Cream was developed especially for doctors and nurses who give their hands so many scrubbings every day. Now Pacquins is the world's largest-selling hand cream! Use it regularly for soft, smooth, lovely hands. For extra-dry skin: red label Pacquins—contains lanolin.**

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FOR DREAM HANDS, CREAM YOUR HANDS WITH

Pacquins Hand Cream

R.N. Contents

December, 1949

Features

Departments

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Vol. 13, No. 3

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	Calories	Protein Gm.	Calcium Gm.	Copper mg.	Iron mg.	Phosphorus Gm.	Vitamin A I. U.	Thiamine mg.	Riboflavin mg.	Niacin mg.	Ascorbic Acid mg.	Vitamin D I. U.
National Research Council Allowances, Sedentary Man (154 lbs.)	2,400	70	1.0	1.2	12	1.5	5,000	1.2	1.8	12	75	Small Amount
Ovaltine in Milk, 3 Servings *	676	32	1.12	0.5	12	0.94	3,000	1.16	2.0	6.8	30	417
Percentages of N. R. C. Allowances Provided by 3 Servings* of Ovaltine in Milk	28%	46%	112%	42%	100%	63%	60%	97%	111%	57%	40%	Abundance

*Each serving made of ⅓ oz. of Ovaltine and 8 fl. oz. of whole milk.

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The aim of the dietary at all times and under all conditions is to provide ample amounts—not just minimum amounts—of all nutrient essentials. Only when the daily nutrient intake is fully adequate can the possibility of adequate nutrition be assured. It is for this reason that a food supplement assumes great importance in daily practice.

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Note in particular the high percentages of the dietary allowances for nutrients and the relatively low percentage of the total calories furnished by the servings of Ovaltine in milk. Thus, without unduly increasing the caloric intake, Ovaltine in milk greatly increases the contribution of nutrient essentials. Enticing flavor and easy digestibility are other important features of the dietary supplement.

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● Vicks VapoRub in Steam brings prompt, soothing relief from respiratory distress... especially when dryness and irritation of the mucous membranes accompany the infection.

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● Important, too, is the fact that Vicks VapoRub is available in most homes. So when any of your patients require steam therapy, be sure to recommend Vicks VapoRub in Steam.

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Thanks

Dear Editor:

This is to thank your readers for the many letters sent to Phyllis Potmesil [**R.N.**, May, p. 7].

Your letters have helped her immensely and have aided her in her convalescence from poliomyelitis. Phyllis is still in the respirator but has progressed to the point where she can leave it daily for increasing periods.

Thanks again for the many letters and cheering wishes for an early recovery.

FRANCES B. MATHEWS, R.N.
OAKLAND, CALIF.

Understand Us

Dear Editor:

Many young graduate nurses today seem to feel that the older graduates are getting out of their share of general duty by only working part-time.

There may come a time in the lives of these same criticizing nurses when they too will be prevented from doing full-time duty because of home problems, recoveries from long illnesses, impairment of health, and many other legitimate reasons.

Rather than give up the care of the sick completely, we older nurses feel it is still our duty to help, therefore give whatever spare time we can to the profession.

When I was still quite a young graduate, we were always happy to have part-time nurses come in to give us a lift when they could spare the time. Can't we go back to that attitude?

EVALENE WRIGHT CASSON, R.N.
TIFFIN, OHIO

Too Many Chiefs?

Dear Editor:

I sometimes wonder if our profession is on the right road. Will we still be entitled to the name "nurse" if we are going to relegate all the bedside nursing to nurses' aides and practical nurses, and only attend to the professional part of nursing?

When the nursing profession organized, it was to nurse and care for the sick. Have we forgotten our original aim? Dr. Esther Lucile Brown in *Nursing for the Future* does not feel that the three-year course is very satisfactory. Will a

one-year course be more satisfactory? She also states that a college course of four calendar years be recommended. Is the length of the course of more value than the knowledge acquired?

If the plans for the future come to pass it seems to me we will have a great many armchair strategists in the profession, but the actual workers will be few in number. I don't believe patients are as much interested in the number of degrees we have as they are in good nursing care, kindness and understanding.

MYRTLE GLASS, R.N.
PHILADELPHIA, PA.

Can We Live Too Long?

Dear Editor:

The article on the older nurse [**R.N.**, May] was most timely. Last year I reached 65 and had to retire automatically from a job I'd held for 20 years, with only two days of sickness in all that time. I entered the job at $1,350 a year and left it on a "take home" salary of $1,999 (after taxes had been deducted).

My job called for the use of a car which I had to supply. Occasionally I got $25 a year for expenses from the board. Out of my $144.30 a month I sent $50 to my family to help purchase our home in another town, at the same time paying for my room and board here. I subscribed to the magazines I needed professionally, and kept up membership in professional organizations.

My pension of $32.30 a month is not enough to carry me so I went to

PREFERRED *by* NURSES 3 *to* 1*

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Nurses in Training. White Glovelk. Duflex Nap White Sole and Spring Heel. Also made with 10½/8 White Heel and Sole.

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THE CLINIC SHOEMAKERS

10th Floor Shell Building . . . Dept. RN-12, St. Louis 3, Missouri

*3-to-1 preference over next most popular brand revealed in independent surveys conducted by the nation's two leading nurses' journals.

the local registry to register for night duty. I was told "We do not register any more older nurses for the doctors don't want them." The medical profession feels it is so wonderful for people to live longer—yet no one wants the old folks around. I am well and strong, able and eager to work wherever I'm needed, yet here I am, afraid because I *am* so well that I will live too long!

WINIFRED E. BOSTON, R.N.
CEDAR RAPIDS, IOWA

A Big Amount of Spirit

Dear Editor:

I read with great interest the article called "Who Should Be a Nurse?" [R.N., July]. Seems to me most readers would say: "She is right with her own answer."

I, too, think insisting on the highest school education possible as a background before enlisting in a nurses' school does not do much good. To become a real nurse one needs different qualities than are necessary in some other professions, where much academic knowledge is a necessity. Nurses need a big amount of the spirit of Florence Nightingale.

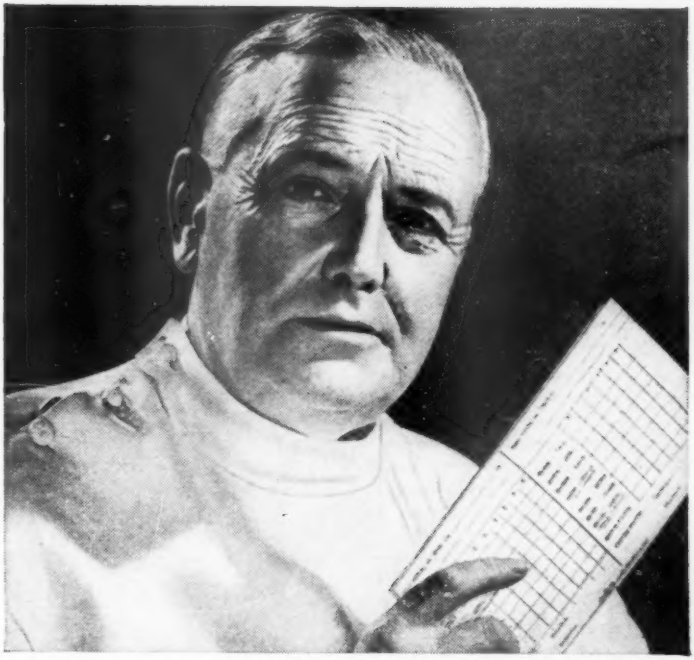
It is a fact that the modern world has not many nurses to offer of the Florence Nightingale type. To look for them would be like looking for a needle in a haystack. Very seldom will nurses reach the level of Florence Nightingale's standing. But it was not her school education which helped her to be an outstanding personality in the nursing profession;

I had my training in the same nurses' school, but more than 50 years later, when the school rather deserved the name. The nurses' school where she got her first professional training hardly deserved the name of a nursing training school. She learned the handling of patients in a real, practical way. A churchman and his wife and one other girl besides Florence Nightingale took care of about six orphan children and some prostitute women. The time of most of them was filled with physical work. The little bit of rest time which was left was used for religious exercises.

Florence Nightingale became what she was by a special gift of the Lord.

The little house where Florence Nightingale had her so-called training was still standing in my time. Most interesting was the small house where the prostitutes had slept. It had two floors, but the only windows were about 20 feet above the ground. There was no door at all. Those women, who did mostly field work in a fenced-in garden, had to use a ladder to enter their dormitory every evening. The ladder was taken away once they were inside, and the windows closed from the outside. This was done to keep them from any connection with the outside world.

The others held their evening sermon and called it a day. The religious part was more important, even in my day, than any theoretical training in nursing duties. We



Throat Specialists report on 30-Day Test of Camel Smokers—

"Not one single case of throat irritation due to smoking Camels!"

• Yes, these were the findings in a total of 2,470 weekly examinations of hundreds of men and women from coast to coast who smoked only Camels for 30 consecutive days! And the smokers in this test averaged one to two packages of Camels a day!

According to a Nationwide survey:

More Doctors Smoke Camels

than any other cigarette!

When three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel!

could skip classes once in a while—and we did—but not the religious services.

The worst ones were our silent prayer meetings, when we were overtired. In long rows we knelt in church and were supposed to stay awake and meditate. We young nurses used several tricks to stay awake, since sleeping was considered a horrible sin. We often took pins along and each one promised to stick the other if sleep should befall her. Sometimes, however, we all slept, and all the pins would lie on the floor. The older nurse, who was supposed to watch us, would then threaten us with fire and brimstone for a whole week.

Young students of today have no idea what we in our time went through. There was no such thing as 8-hour duty. We started at 6 o'clock in the morning and stopped at 10 p.m. There was no recreation in between—only church and lunchtime. On Sundays we marched singing with older nurses over the fields which belonged to the Motherhouse.

We received the main part of our actual nurses' training in out-of-town hospitals where we were sent after about two years of school. Those hospitals were more or less connected with the Motherhouse.

My first assignment was to one of the biggest hospitals in Berlin, which had more than two thousand patients. For a time I was a sort of floating nurse in the children's wards.

From there I was sent to Bonn where I started with night duty. The hospital was small with only two

"That lady has friends...see those FLOWERS!"

Yes, real friends rally round at convalescent time, sending FLOWERS-BY-WIRE. Both help patients feel better, faster, especially the FLOWERS.

And most F.T.D. members deliver Hospital FLOWERS in containers filled with chemically treated water that needs no replenishment.

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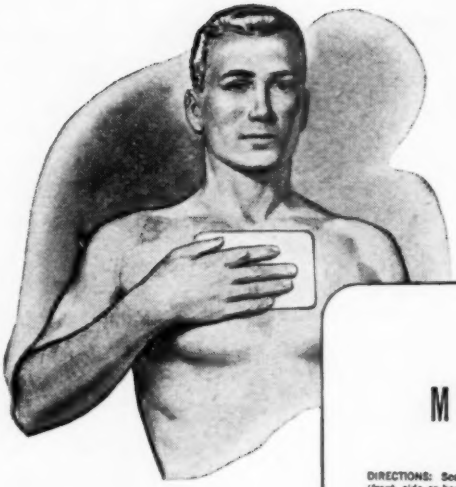

Johnson's

MUSTARD PLASTER

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DIRECTIONS: Soak the plaster in lukewarm water (1 to 2 minutes) and apply to chest (front, side or back). Remove plaster when skin is thoroughly reddened, usually within 5 to 10 minutes.

CAUTION: Do not keep plaster on long enough to blister the skin—never over 15 minutes. If blistering occurs because plaster is left on longer than 15 minutes, apply Johnson's Baby Cream or Petroleum Jelly to soothe the irritated area. When used on children or adults with sensitive skin, place a layer of wet gauze or cloth between plaster and skin.

A Johnson-Johnson PRODUCT

For chest colds

The time-proved mustard poultice in modern, ready-to-use form

The old-fashioned mustard poultice has long been recognized as sound therapy. For example, Blumgarten's "Textbook of Materia Medica, Pharmacology and Therapeutics," 1937, notes that rubefacients or counter-irritants are useful "to relieve pain and tightness in the chest and congestion and inflammation in the lungs."

Whenever this type of treatment is indicated, you will find that Johnson's MUSTARD PLASTERS offer many advantages to your patients. Each plaster comes ready to use. Nothing to prepare. No mess. No fuss. On and off in a few minutes. Heats the spot, stimulates circulation, helps relieve chest colds, bronchitis, sore throat.

Johnson's MUSTARD PLASTERS *are the only form of mustard application recognized and approved by the United States Pharmacopoeia.*

For a free sample, write to Johnson & Johnson, New Brunswick, New Jersey. This offer is limited to the continental United States.

Johnson's **MUSTARD PLASTER**

general duty night nurses. We went in the morning to a cabin in the mountains where we slept. At 5 p.m. we had to be back in the hospital to make five to six hundred sandwiches for the patients' second breakfast the next morning.

By my second year in Bonn I was assistant nurse in surgery and soon became anesthetic nurse for one of our famous surgeons. After Bonn I was sent to Dusseldorf to collect some knowledge about ears and noses. My mind was not with me, so I did not get what I should have from the experience.

One thing is sure—after three years of training I thought I knew everything. Now, after 50 years of working as a nurse in all fields in peacetime and wartime, I think I know nothing.

HEDWIG WAGNER, R.N.
LOS ANGELES, CALIF.

Suggestions Please

Dear Editor:

The Wesson Memorial Alumnae Association of Springfield, Mass. is interested in developing a Free Bed Fund for Sick Nurses. The Association has a sizable sum saved toward this project, and the members are interested in learning the methods used in other institutions to manage and govern these funds.

Perhaps some of your readers would be able to assist the committee in making a decision on this important question.

GERTRUDE M. LYONS, R.N.
HAMPDEN, MASS.

Typical nurse's uniform 1865

Styles change...

but surveys show
nurses ***still*** prefer:

1. WHITENESS IN A WHITE SHOE CLEANER
2. GRIFFIN ALLWITE OVER ALL OTHER BRANDS

You asked for it . . . you get it . . . in Griffin Allwite! Coast-to-coast surveys show that you want *whiteness* in a white shoe cleaner . . . and prefer Griffin Allwite over all other brands! And no wonder . . .

Griffin actually makes your white shoes whiter than new! It's easy to apply . . . cleans well, too! Griffin resists rubbing off. And it's made with all the scientific skill of an ethical product—it's perfectly safe for *all* white shoes.

Whether you prefer the convenient bottle or the handy tube, always ask for the nurses' favorite—Griffin Allwite!

10¢ & 25¢ bottles • 15¢ & 25¢ tubes

GRIFFIN ALLWITE

Science Shorts

A droopy-drawer diaper, or in other words, an arc-shaped waterproof nylon container for a disposable pad, has been advocated for babies by two Cleveland men, one a physician, who found that the new pants were comfortable, odorless, reduced contamination of body, bed and clothing, and lessened the incidence of skin rash and intertrigo.

*

The cancer death rate among white female policyholders between the ages of 1 and 74 of the Metropolitan Life Insurance Co. has declined 11 per cent in the past 10 years, according to the Company's Statistical Bulletin.

*

The Medical Advisory Committee on Beryllium has advised that care should be taken to avoid cuts from broken fluorescent lights since these wounds heal slowly and may cause swelling. Used lights should be broken out of doors in a waste container to prevent inhalation of dust. There is no danger from intact lights.

*

An article in the JAMA *by Drs. H. Harris Perlman and Irving L. Milberg states that 27 out of a group of 41 patients with psoriasis showed improvement after oral administration of undecylenic acid, a drug resembling the natural oils of the skin.*

*

While childhood mortality from infection has decreased markedly, deaths from other diseases have moved up the scale. At ages one to 14, cancer, including leukemia (most common type of fatal cancer) and Hodgkin's disease, rates as second cause of death; from five to nine it stands first.

*

Coricidin tablets (Schering Corp.) containing Chlor-Trimeton, an antihistaminic drug, are based on the new concept that colds are an allergic response in susceptible persons either to the cold virus protein or its products.

*

Vitamin B_{12}, prepared commercially from cultures of Streptomyces griseus, the source of streptomycin, "is probably the most potent therapeutic agent known," according to Dr. Lowell A. Erf in an article appearing in *Philadelphia Medicine*. Of no demonstrable value in secondary anemias, it is most effective in the macrocytic anemias which do not

show free hydrochloric acid in the gastric juice. In pernicious anemia it aids in the maturation of immature erythroid marrow cells, the myelinization of nerve tracts and the nutrition of the gastro-intestinal mucosal cells. The vitamin, available as crystalline B_{12} and B_{12} concentrate, is also present in various liver extracts.

*

Although some foods must be fortified to substitute for nutrients removed in processing, meat retains its chief nutritive value during processing, according to an item in Food and Nutrition News.

*

A study of 106 patients at Gallinger Hospital, Washington, D.C., reported in the *Annals of Internal Medicine* [Feb. 1949], reveals that caronamide, a drug inhibiting the renal excretion of penicillin, raised the penicillin serum level four times above that obtained from oral or parenteral use of penicillin alone.

*

An American Pharmaceutical Association report on rheumatic fever notes that this disease accounts for 90 per cent of the defective hearts in children and one-third of those in adults.

*

Benzedrex, a nasal inhaler, manufactured by Smith, Kline and French, replaces the firm's Benzedrine inhaler. Benzedrex is said to shrink the nasal membranes in head colds, hay fever and sinusitis more effectively than the Benzedrine inhaler and, more important, cannot be misused for stimulation purposes.

The Importance of Safety in Antihistamines

. . . SOME COLD FACTS BROUGHT TO YOU BY THE THERAPEUTICALLY EFFECTIVE AND SAFE ANTIHISTAMINE

ANAHIST
TRADE MARK

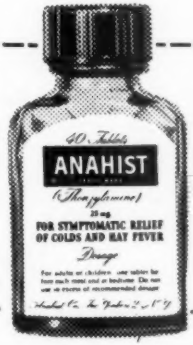
1. There continues to be a great difference in performance and safety of the antihistamines now offered for sale.

2. ANAHIST'S chemical compound has a rigidly controlled clinical background of effective and safe use for colds.

"Particularly useful in patients unable to tolerate other antihistaminic drugs." Wayne University.

3. It is now possible to control and prevent the spread of the common cold, both safely and effectively, with ANAHIST 25 mg. antihistamine tablets, taken upon exposure or at the first signs of a cold.

★Dosage: One ANAHIST tablet four times a day, after meals and before retiring.



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R.N.

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for soft hands that smooth the way thru the day

Now you can have those well-groomed hands *On Duty* as well as *Off Duty*—in spite of the drying damage of frequent scrubbings, soap and water.

with TRUSHAY that is

For **TRUSHAY** starts off by being the most luxurious softener that ever smoothed your skin—rich as cream—but without a trace of stickiness. It's sheer delight to use at any time.

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For **TRUSHAY** does double duty with its unique "beforehand" extra. Smoothed on *before* frequent washings, **TRUSHAY** protects your hands even in hot, soapy water—guards the skin by helping to preserve its natural lubricants.

Begin today to use **TRUSHAY**—*and when patients admire your well-groomed hands, tell them about the lotion with the "beforehand" extra,* **TRUSHAY**.

***Product of* BRISTOL-MYERS • 19 West 50 Street, New York 20, N. Y.**

R.N. Speaks: CAN WE A

■ ONE OF THE MOST hotly contested issues ever to come before the delegates of any state nurses association was that of whether the New York State Nurses Association should become the collective bargaining agent for its 13,500 members. After three days of fiery, emotional debate the motion to do so was killed by the NYSNA's delegates to the sixth biennial convention by a majority vote. However, the Association did approve the ANA Economic Security Program, minus its collective bargaining features (see page 37).

The principle of collective bargaining is generally accepted as just and fair by our government and the majority of people in this country. It is one that workers have struggled to attain for years. It is a recognized device used by labor unions. In general, its principle had not been adopted by a major professional group until the ANA house of delegates took its stand at Atlantic City in 1946.

Many within the profession strongly doubt whether the majority who voted to give individual states the right to engage in collective bargaining for their members if they so desire had any idea to what they were committing the profession. The fact that three years later many states, while approving the national program of promoting economic security for nurses, have not wished voluntarily to avail themselves of the bargaining feature shows that second thought gave serious pause. Granted that the adoption of this feature has been in some instances precluded by the presence or absence of specific state labor laws, more often when collective bargaining tactics are not used it is because those states are adverse to adopting procedures where there would be danger of classification as a "labor union." Consequently, despite the increased pressure of the high-powered national program, such states prefer to experiment with cooperative planning which is dependent upon enlightened public opinion rather than resort to collective bargaining and all it implies.

Before a program of such magnitude and of such a controversial nature snowballs to an unmanageable size, it should undergo mature studied reflections and open discussion within all the local professional groups. It is safe to say that as yet the collective bargaining technique

AFFORD IT?

as used by nurses has not been tested long enough to convince many of us of its superiority over its alternative method.

Economic security involves two basic approaches: the first, a realization and conviction of its need and the second, the means by which it should be attained. There is little doubt that nurses generally want better economic protection than they now have. The practice of nursing has in it both the hazards of unusual fatigue and excessive exposure to disease; these two factors alone often demand early retirement.

From the viewpoint of the community which finds nursing essential to its well-being, nurses must be better protected. From the standpoint of common justice, nurses should be given the basic protections that are accepted by all workers as their due. But the means of achieving this desirable end constitutes a quest of major importance. And the price that is paid for its attainment should be considered.

"Security" is one of the words we hear today in increasing frequency. To many it has come to mean freedom from war and poverty; freedom from fear and danger. In nursing the word has become synonymous with better rewards for nurses both in terms of today's pay and tomorrow's pension. Security is a social word—no one wants to argue against it, everyone is in favor of it.

The question is, are we over-concentrating our forces to obtain economic security for nurses? Perhaps no single phase of the ANA's entire program gets more, or as much, attention as its Economic Security Program. Admittedly, nurses want something more than drudgery and sacrifice, but is the pendulum swinging too far to the left? Can the accusation by the public that registered nurses are developing a taste for unionism, but in a more diluted form, be shrugged off? Have we thought of just what we mean by security; can any security be sound and enduring if it is based solely on materialistic gains?

Some nurses are troubled with the profession's apparent over-preoccupation for better pay for nurses. Although favoring better working conditions and remuneration, it appears to them that there is an inordinate proportion of the profession's [*Continued on page* 69]

CANCER FILM REVIEW

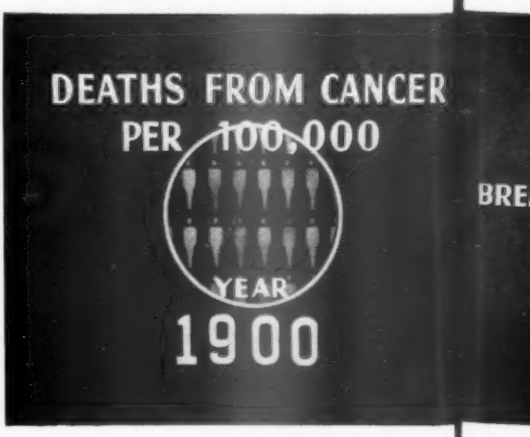
■ IT MIGHT SEEM unusual that nurses should be asked to study so baffling a disease as cancer since cancer challenges the intelligence and highly skilled techniques of surgeons, pathologists and experts in internal medicine. However, this is erroneous thinking, for the nurse who understands cancer contributes immeasurably to the conquest of the disease and the care of cancer patients.

The Nursing Staff at Memorial Cancer Center, N.Y.C., subscribed to this belief through the long weeks when the film *What Is Cancer?* was being shot, when our attention was distracted by the big 16-millimeter Mitchell camera rolling through the halls to the laboratories or operating rooms; and when we were asked, over and over again, to supply nurses for patients being photographed or to help find cases to illustrate important points in the script.

The experience of working with the American Cancer Society and Audio Productions to produce this new 25-minute teaching film for nurses has been time-consuming but well worth while. We are pleased with the result because, in these months of work, we have helped to create a film which Dr. Cornelius P. Rhoads, director of Memorial Center and one of the outstanding figures in cancer research, believes to be one of the finest pieces of teaching material on cancer ever prepared for nurses.

There are many reasons why nurses who care for cancer patients have long needed a basic film of this kind. But perhaps the principal reason is that a nurse must have a basic understanding of the physiological condition which caused her patient's illness in order to be intelligent in her care of a cancer patient.

In cancer—as the film graphically shows—the basic physiological condition is abnormal cell growth. In this film, while the commentary describes cancer, as it has been described in lectures and texts many times, cell growth is actually seen; first, that of normal cells and then of cells that have spontaneously become cancerous. Consequently, instead of laboring to arrive at a conception of how the disease starts, the nurse seeing this film grasps the primary condition in a matter of seconds and begins to develop an emotional and intelligent understanding of



by Caroline Keller, R.N.
and Margaret Coleman, R.N.

what cancer is and *why* it must be treated.

What we call the "cell sequence" is undoubtedly the highlight of the film. However, there is an abundance of other good teaching material and a narrative introduction which revives the earliest known records of the disease.

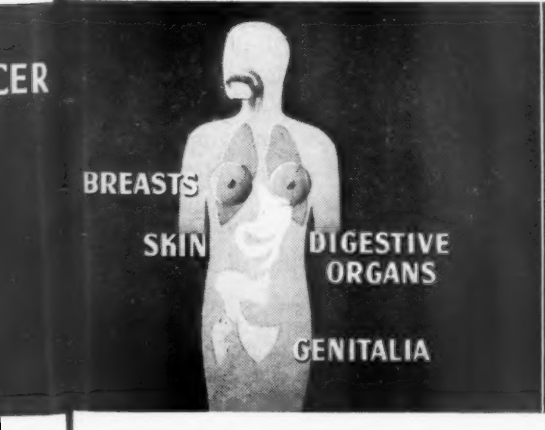
Following the introduction, the film flashes briefly to the scene of Dr. Theodor Billroth's first successful operation for cancer of the stomach, performed at the General Hospital in Vienna in 1881. This incident marked the beginning of the modern surgical attack on cancer.

The discussion of the biology of cancer, and the cell sequences described above, lead into a section on carcinogenic agents and conditions which often prove to be pre-cancerous. The symptoms of cancer, usually called the "7 Danger Signals," are given.

A section then follows on the cancer's metastatic spread through the vascular and the lymphatic systems. Standard methods of treatment, plus hormone therapy for palliation, are also described.

The film points out that while the mortality rate for five common sites of cancer—breast, cervix, stomach, rectum, lung—averages from 65 to nearly 100 per cent, the mortality rate could be reduced appreciably by early diagnosis and effective treatment. *How the nurse can help to achieve this reduction is the closing theme of the film.*

At Memorial Cancer Center we'll use the film about once a month in our staff education program. We believe many directors of nursing will find that they have as much need of the film as we have. We think that a nurse who sees this film will couple her observation and care of a cancer patient with a sharper and more intelligent recognition of symptoms. Interest and intelligence on the part of the nurse are sensed by patients,



many of whom need encouragement to maintain the psychological health so necessary for physical recovery.

The nurse has an inestimably important role to play in the conquest of cancer, one that can give her a great feeling of satisfaction in her work. It is conservatively estimated that cancer mortality can be reduced by half if present day knowledge is used. This is a challenge that no one in the nursing profession can conscientiously choose to disregard.

* * *

Prints of *What Is Cancer?* are available for loan or purchase. Borrowers may secure the film through the 60 division offices, state and metropolitan branches of the American Cancer Society. Prints may be purchased for $115 from the national office, located at 47 Beaver Street, New York 4, N. Y. The American Cancer Society provides supplementary materials to be used along with *What Is Cancer?* There is a pamphlet for program chairmen and a "take home" folder for nurses which contains the fundamental teaching points made in the film. The Society plans to follow *What Is Cancer?* with three films that will emphasize nursing techniques in cases of cancer of the breast, rectum, and head and neck.

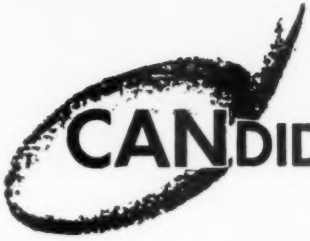
CIRCULATING ART LIBRARY

● BED-RIDDEN OR HOUSE-BOUND PATIENTS are enjoying the loan of prints of good pictures from the Rochester Art Gallery, through the cooperation of visiting nurses.

The pictures are available on a three-week rotating basis, like a library book, from a group selected by the art gallery staff as most suitable for patients not only because they are "good art," but because they have life and color. They include still lifes (mostly flowers), landscapes, and genre scenes involving people of all ages as well as animals.

When a nurse has a patient who is interested in having a picture, the information is phoned to the art gallery, where a voluntary "art aide" selects a print, takes it to the patient's home, and hangs it exactly where the patient wants it. Three weeks later, another picture is made available in the same manner. All the prints have inexpensive beige wood frames, and are without glass. A label on the back gives the title and number of the painting, artist's name, school and dates.

The response has necessitated increasing the number of prints in this collection. Some patients feel that the pictures have a definite therapeutic effect.



CANDID COMMENTS——

The Art of Communication

WE ARE OFTEN accused of being an inarticulate profession—and justly so. This is especially true in the written word. We need to be more articulate in our contacts with our allies and our public. We tell them of our needs. We should tell them the story of ideals and service that underlies these needs.

We cannot cooperate willingly and wisely unless we understand the *why* of these things. We cannot gain and hold allied and public support unless we are able to interpret to them our philosophy as well as our need. We need to know each other better. The public needs to know us better. We need to know the public better. Public opinion is the driving force behind all law and action. There is no finer single public relations agent than the average nurse who daily deals with some part of the public. Her actions, attitudes, service express our ideals in one way. What she is able to say in the spoken and written word expresses them in another.

We need to be more articulate too in our internal relationships. We need not only to understand each other better; we need to be able to *tell* each other better. As in all highly specialized professions whose work is intensive and driving, there are walls between our various branches. How many, outside of the educators, know the major problems of nursing education? How many of those who so easily dismiss private duty as a "terminating" field, have tried to understand why it persists so strongly in spite of long discouragements? How many understand the growing complexities of industrial nursing, public health nursing, office nursing, nursing administration? How many, away from hospital floors, know the problems of staff nursing? Yet all our ideals and problems stem from the same source—a desire to serve well. Only through telling as well as listening to each other can we find the common denominators of nursing and develop the mental and spiritual unity that must underlie unity in structure.

Recently the editor of **R.N.**, after searching through the early volumes of nursing publications, commented, "How very little of the early writing for nurses was done by nurses!" Slowly over the years more nurses have taken pen in hand to augment our literature. Books have increased greatly in number—excellent books, but in the main on subjects confined to highly technical matters. The

by Janet M. Geister, R.N.

early editions of *Trained Nurse and Hospital Review*, which preceded the *American Journal of Nursing* by 12 years, contain many formulas and many simple nursing instructions. Today such things are handled in textbooks and manuals, and more and more nurses are contributing well-written articles of wider interest to our publications. But in terms of our growing stature, the number of writers is still far too small and the range of subjects still much too limited. This new interest indicates a growing sense of responsibility on the part of the individual nurses. It is part of the ground swell that, in my opinion, is raising nursing to newer heights. The profession has grown up fast in the past few years.

We have an obligation for more of us to learn how to express ourselves in both the written and spoken word. Talking on the way home from meeting may release steam but it doesn't change ideas. We should know what it's all about and be able to meet opposing ideas with something more than shopworn prejudices, and to ask our officers and executives for more sustained programs of information so that we can know.

The hour is here for something more. "Problems are facing nursing today so different in character from many of those in the past that we are in urgent need of a whole new literature," writes Mary Ella Chayer.* Our world-view has changed, is changing. "Every person, whether primitive or highly civilized, has a conception of himself and the universe in which he lives and works or idles. This is his idea of his world—his world-view . . . a world-view is in the mind of every man and every woman."* So is it with a profession. Its concept of its place in the scheme of things is its world-view.

In our old world-view our purposes were simple and singular. We worked to keep our patients from dying. We still do, but our concern with the patients has broadened to include their psychological, health and rehabilitation needs as well. Where once every nurse could work successfully within her orbit of private or staff duty, today we must integrate our work with that of others. A private duty nurse volunteers to help out in a polio epidemic. She at once becomes a part of a combination of agents, ranging from the National Foundation for Infantile Paralysis and the American Red Cross to the hospital orderly. The nurse in industry and the public health nurse have a common tie—the health of the worker and his family. The early hospital was an isolated, independent unit; today it is rapidly emerging as a community health center.

The world-view of the profession and of every nurse in it must broaden. No nurse, however remote, can escape the effects of every ac-

*"Of Books and Authors," *AJN*, Dec. 1948

*_The American Spirit_, Charles and Mary Beard, The Macmillan Co., New York.

tion taken by our organized bodies of nurses. They in turn are affected by what she thinks and does. The student of today, in contrast to the student of yesterday, enters an adult profession working to discharge more fully its obligations to the community. As she becomes a nurse she assumes a community responsibility *as nurse* as well as citizen.

We are as interdependent as are the cells of our bodies. One of the great discoveries of the times is the realization of the interdependence of mankind. Our country is investing huge sums of hope and cash in other countries because our own well-being is threatened when that of other countries suffers. The present wide gaps in our nursing service are perhaps a result of the profession's failure to see itself as a part of the larger community. Our growing awareness of this has brought a demand for new departures in nursing education, practices and economics that has resulted in considerable confusion within the ranks.

There is no better way of understanding the world-view of nursing than to begin with understanding our own. On what basis do *I* approve or disapprove the actions recommended to me? And there is no better way of understanding our own views than to reduce them to the spoken or written word. Before we can speak or write so that others can get our meaning we have *to think*. The half formed opinions that rummage about in our minds have to be sharpened and trimmed before they

Probie

"It's a tree-trimming."

can command our neighbor's respect. Writing is a greater test than speaking because the speaker's charm, his jokes and shrugs can cover up an absence of thinking. "His speeches leave the impression of an army of pompous phrases moving over the landscape in search of an idea," William G. McAdoo wrote about a prominent man. In the written word we have to be exact. No tricks can cover up inadequacies in thinking.

A new literature does not necessarily mean we must all set to writing books or try to break into the great popular magazines with stories about nursing. But more nurses must do these things and more will when more of us are willing to undergo the discipline of writing. There is value too for each of us in what we reduce to writing. Then we really know what we think. In my own experience I've been startled time and again by the difference between what I *thought* I was thinking and what actually evolved when the idea got down on paper. On one occasion it took nine re-writes of a paper before my mind got the better of my emotions. My mind had a good idea but my emotions muddled it. Only the written word revealed the fact.

When we know what we think and why we think it, the idea is ours! We can defend it before any court. We can proclaim it in any company. Until we can do so, our thoughts aren't ideas but just opinions. And though all nurses cannot write books and articles, we need to have many more try to do so—willing to sweat out the labor of putting ideas into simple clothes. We have lost immeasurably because our pioneers hadn't the time to put the grandeur of their struggles into written words. Our history books are crammed with facts, but they lack the color that gives the picture depth and perspective. We are woefully poor in biography, a form of writing that energizes history.

We need nurses who will sit on mountain tops and write us a perspective of today and tomorrow. And we need nurses who write plain little pieces that tell us what nurses are thinking about, of their experiences in the every-day drama of nursing, of what they do not like and would like in the way their professional affairs are handled.

But what if all our articles aren't published? They should not be, they aren't worth it. But one try leads to another, and only our very best is worthy of print. Writers are made, not born. We may have a talent just as we have for nursing, but we don't get to be *professional* nurses without hard work in developing that talent. Speakers and writers aren't born with microphones and typewriters in their hands. Thomas Edison ascribed his achievements to "5 per cent inspiration, 95 per cent perspiration." That goes for real achievement in any area.

There are excellent books and courses on the techniques of writing but the first requisite is to have something to say. The finest techniques can't [*Continued on page* 55]

Better Be SAFE Than SORRY

by Marjorie Ann York, R.N.

● EVERY NURSE knows that drugs can be dangerous but the public may not be so wise. Newspaper accounts of accidental deaths from drugs—especially sleeping pills—are disturbingly frequent.

Although we have the Food, Drug and Cosmetic Act and the Harrison Narcotic Act, events have proved that unless pharmacists, doctors and nurses pay special attention to their responsibilities under these laws, the public will not be fully protected. Attention is currently being paid to the refilling of prescriptions, a practice that has been much abused. It is now recognized that under the Food and Drug Act, a pharmacist cannot refill a prescription item unless he has special authorization from the physician. Many states during recent years have passed laws which prohibit the dispensing of certain drugs without prescription.

In the light of this present-day concern with the dangers of drugs it might be well for the nurse to review her part in administering drugs and check to see if she is leaving any loopholes for mistakes—mistakes that could mean the loss of a patient's life and the end of a professional career.

These pertinent pointers are designed to help the nurse administer drugs safely:

► In the hospital or, if feasible in the home, store all medicines in a tightly-locked closet, and keep the key in your possession. Arrange the drugs in some sort of alphabetical order, with the labels plainly visible. Put drugs that have a similar action together, i.e., sedatives, cathartics, etc. Internal drugs should be in one group, external in another and narcotics in a completely separate place. Keep oils, vaccines and serums in the refrigerator.

► See that the medicine cabinet is well-stocked, but not crammed with an oversupply. Make sure that all bottles are securely corked and labeled, and that both bottles and labels are clean. Note the closet's contents each day, and examine the drugs for any change in odor, color and consistency. Eliminate out-dated drugs.

► Whenever possible don't prepare labels for [*Continued on page* 57]

The Cold War

● REACH for a handkerchief. "Cold" weather is here and once again offices, subways and concert halls resound with the sneezes and wheezes of the common cold.

The common cold, known as acute rhinitis or acute coryza in medical circles, hits its stride with the first sharp breath of autumn and runs at a varying epidemic rate throughout the winter and spring. At present there is no overwhelming evidence to suggest that this year's incidence of the cold will be curtailed even though scientists and doctors are redoubling efforts to discover its cause and cure.

The cold is not a disease to be sneezed at. It is held responsible for 150 million days lost from employment per year and for costs to the public totaling more than one billion dollars. Staggering statistics for an affliction generally considered to be minor and inconsequential!

The cold itself is not so time-consuming as the upper respiratory infections which may follow in its wake, such as sinusitis, otitis media, pharyngitis, laryngitis and pneumonia. Once a person develops a cold he is more susceptible to the secondary onslaught of bacteria already present in the respiratory passages or in his environment.

The organism primarily responsible for the cold has been tentatively identified as a filtrable virus, the initial invader that opens the door to bacteria. But, it has been fairly well proved that factors such as changeable weather, extreme air-conditioning, fatigue and generally lowered resistance allow the cold virus and its attendant bacteria a wider scope of action. Consequently, the oft-disregarded advice to put on rubbers, change wet shoes, and wear a sweater in cool weather is not due to the caprices of a maternal mind; it is based on evidence.

One easy way of picking up the cold virus and bacteria is to frequent crowded places, such as subways, trains and movies where you are most likely to be exposed to the coughing and sneezing multitude. Nearly everyone has seen the photograph of a sneeze showing the dangerously wide range of infectious droplets. From the evidence of such photographs the average sneeze can be seen to travel about two or three feet. And it shouldn't be forgotten that organisms are also released from the mouth during the involuntary act of sneezing.

The recipient of the cold virus, the nose, which takes most of the beating in a cold, is normally able to repel bacteria and dust by an ingenious cleaning system. The hairs at the entrance of the nostrils filter out the coarse dust particles

while the escaping ones are deposited on the nasal membrane equipped with a layer of mucus and fine hairs called cilia. The mucus entraps the particles, which are then propelled to the throat by ciliary action to be discharged or swallowed. The fact that bacteria can, in this manner, be disposed of within a few minutes contributes to an almost sterile nasal environment. It has also been shown that a substance called lysozyme, present in nasal secretion, has some bacterial-destructive properties. A few researchers have pointed out that the quantity of lysozyme in the secretions is lowered before the onset of the cold, and have endeavored to find some substance which might increase this bacterial foe.

Some of the ways in which the public seeks to ward off colds are worthwhile; others, based on folklore, are worthless. One commonsense preventive for all diseases, colds not excepted, is keeping the body's resistance at high peak by an adequate amount of exercise and sleep, balanced diet, avoidance of drafts and unusual temperature changes. But while all of these measures tend to heighten the body's resistance, no one can be said to actually prevent colds, neither will unusual attention to or exaggeration of any one of these factors bestow cold immunity. The food faddist who relies on vitamins or certain alkalinizing foods appears to be just as susceptible as the cold-shower enthusiast. There is no truth to the theory that exposing the body to the elements will gradually condition it to withstand cold infection. Rugged outdoor athletes have been shown to be as prone to colds as the inveterate radiator huggers.

Nose and throat antiseptics are also of little help in warding off the cold germs. The average mouth wash rinses the mouth and makes it feel clean but actually the solution remains in the oral cavity too short a time to be of bactericidal value. As for the nose, that organ has its own sterilizing system which works best when left alone.

Cold vaccines are a controversial subject. Those vaccines, containing mixtures of bacteria found in the

Ewing Galloway

nose and throat of cold-afflicted persons, have been hailed as wonderful or worthless. Since there is no means of vaccination against the virus, these inoculations are merely aimed at protection against the secondary bacterial invaders. The *JAMA* has stated that "The scientific evidence against the value of *oral* cold vaccines is overwhelming."*

So much for *preventing* a cold. Now what are you going to do about that first irritating, tickling sensation in the throat, the concomitant running nose, aches and pains and general feeling of bodily distress. You may be advised to do many things by your friends who will regale you with their pet remedies—"that really work."

Let's consider some of these remedies in the light of scientific evidence and see how efficacious they really are, remembering this statement recently made in the *JAMA:* "Authoritative medical opinion supports the view that no substance or combination of substances available at present can be relied on to prevent or cure the common cold."** For this reason, we have to evaluate cold remedies in the light of whether they really help to mitigate cold symptoms, making the victim as comfortable and happy as is possible under the circumstances.

A well-balanced, digestible diet seems to be the answer to the dietary requirement. Medication of baking soda to promote alkalinization is not supported by scientific facts. Thirst is a good arbiter of how much fluid to drink; the theory that excess fluids will wash the poisons from the system does not hold water. Similarly, it is not advisable to use cathartics and laxatives excessively, since these may lead to dehydration. This, however, does not preclude their use when indicated. Sweating is another rigorous measure not advised; a person who perspires profusely is liable to become overchilled if exposed to drafts.

In fact, rigorous measures are not called for at all. The more passive treatment of bedrest and warmth has proved the test of time. In the early stages of a cold, heat in the form of electric pads, hot water bottles and hot drinks may reduce congestion by increasing circulation, thus often thwarting the cold's progress. One time-honored remedy, alcohol, also increases circulation. According to Noah Fabricant, author of *The Common Cold and How to Fight It*, an Eastern doctor facetiously gives his cold patients the advice taken from an old English book; namely, "To hang one's hat on the bedpost, drink from a bottle of good whiskey until two hats appear, and then get into bed and stay there." Only the latter part of this advice is, of course, intended for readers' consumption.

In the first stages of a cold, the inhalation of steam will supply much-needed moisture to the upper respiratory passages. That clogged nose will also respond to vasoconstrictor solutions administered by dropper or [*Continued on page* 66]

JAMA, October 8, 1949, p. 426.
**Ibid.

FIREWORKS

AT A STATE CONVENTION

Sparks Fly As New York State Nurses Discuss Controversial Issue of "Collective Bargaining"

■ SPOKESMEN for 13,500 nurses comprising the house of delegates of the New York State Nurses Association met in Buffalo October 17-21 to transact the Association's business. In a busy five-day meeting, including six business sessions, they approved an economic security program while rejecting collective bargaining; advocated one national nursing organization; went on record as opposing compulsory health insurance; reelected Mrs. Mabel Detmold of New York City president for another two-year term. They also endorsed the 1950 platform calling for promotion of federal and state plans for financial aid for nursing education, serious efforts to include nursing service in prepayment health plans and continued action in removing nurses from non-nursing duties in hospitals and health agencies. Opinion was seldom unanimous and discussion was lively and many times heated.

Most of us believe in the democratic process of government, both for our country and for our professional organizations, yet we are often impatient with the necessary procedures of democratic government.

As a profession we probably tend to have too many meetings on the local level. It is essential, however, that problems be talked out, that each group and faction have a chance, not only to state their own views, but to hear the opinions of other groups and individuals. It is the pooling of knowledge and opinion from a large geographical area and the discussion of all the delegates assembled as to the action to be taken that makes up a state or national convention.

Attendance at a convention can be a stimulating experience but conventions, for the conscientious delegate, entail work too: long hard hours of work attending ALL business sessions, listening to both sides of every motion, asking questions, speaking for or against the proposition if the delegate's point of view has not been covered by a previous speaker. And finally, most important, decisions must be made on the basis of arguments presented and votes cast for or against the motion.

Business meetings can be interesting but there is always a long list of reports which must be presented and voted upon by the membership. [*Continued on page* 63]

by Anne M. Goodrich, R.N.

Drug Digest

ACETYLSALICYLIC ACID U.S.P.
(Analgesic)

PROPRIETARY NAMES: Aspirin (manufactured by a number of pharmaceutical firms)

PHARMACOLOGY: Acetylsalicylic acid, commonly known as aspirin, is a salicyl compound which helps to reduce pain of headaches, joints and muscles by a depressant action on the central nervous system. As an antipyretic it reduces fever by increasing peripheral blood flow and by promoting hydration of the blood and sweating. It is almost a "specific" for rheumatic fever because of its action in relieving the inflammatory joint symptoms—pain, swelling and heat. Aspirin is employed in a cold not for its curative value but for its symptomatic effect in headache, fever and muscle pain, and also in a gargle for its local anesthetic action in a sore throat.

DOSAGE: Average dosage, 0.3 to 0.6 Gm. q. 4 h may be administered with sodium bicarbonate in equal dosage to lessen gastric irritation. Water is also given freely after administration to promote free dilution and reduce gastric irritation. Aspirin is available in gum or troches to relieve sore throats.

UNTOWARD ACTIONS: Symptoms of salicylism or aspirin overdosage are tinnitus, vertigo, headache, impaired hearing, dim vision, sweating, thirst, delirium, skin rashes, nausea and vomiting. Subjects allergic to the drug may react with vascular paralysis and shock even after small doses. For this reason, aspirin sensitivity should always be determined before administration.

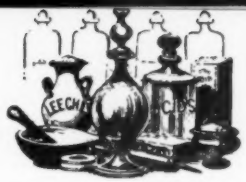
NAPHAZOLINE HYDROCHLORIDE N.N.R.
(Nasal Decongestant)

PROPRIETARY NAMES: Privine Hydrochloride

PHARMACOLOGY: Naphazoline hydrochloride acts as a nasal decongestant by means of its vasoconstrictor properties quite similar to those of epinephrine whose site of action is thought to be the effector cells innervated by the sympathetic nerves. When applied to the nasal mucous membranes it helps to reduce the swelling and congestion resulting from acute coryza, sinusitis, ethmoiditis and allergic rhinitis. The preparation has a pH of 6.2—6.3 which compares favorably with the normal pH of nasal secretions. It is claimed to restore and preserve ciliary activity.

DOSAGE: Privine is available in solutions 0.05 and 0.1 per cent and in a 0.05 per cent nasal water-soluble jelly in collapsible tubes. Only the 0.05 per cent preparations can be obtained without prescription. Two or three drops of the solution may be instilled in each nostril repeating every two to six hours as necessary. The solution may also be used in a spray or on tampons or packs.

UNTOWARD ACTIONS: Too frequent application to sensitive nasal mucosa may result in secondary congestion caused by irritation. Children should be given only the weak 0.05 per cent solution. It has not been proved whether this drug, like epinephrine, increases blood pressure but this possibility must not be overlooked. The solution should not be used in aluminum atomizers.



CODEINE SULFATE U.S.P.

(Cough Depressant)

PROPRIETARY NAMES: Many commercial preparations are available.

PHARMACOLOGY: Codeine sulfate, an alkaloid of opium, resembles morphine in its analgesic and respiratory depressant action, but since it is markedly weaker, produces almost no constipation, euphoria and addiction. It is frequently prescribed for a cold to depress the coughing reflex. Its use with papaverine, an antispasmodic opium alkaloid with no narcotic action, has also been advocated by some authorities in the general treatment of a cold. Elixir of terpin hydrate containing 39 to 44 per cent alcohol, glycerin, syrup and distilled water and other ingredients, is employed as a vehicle for codeine to relieve coughing, though codeine is thought to be this mixture's chief effective agent.

DOSAGE: Average oral dosage of codeine sulfate is 15 mg. administered q. 4 h as needed. Copavin, a commercial preparation of codeine and papaverine, is available in pulvules and tablets containing 0.016 Gm. of each drug and in a compound, each fluid ounce of which is equal to two tablets—an average single dose. The average dosage of elixir of terpin hydrate and codeine is 4 cc. containing 8 mg. of codeine.

UNTOWARD ACTIONS: Overdosage may lead to narcosis, extreme exhilaration, convulsions and circulatory depression. Symptoms to watch for are nausea, vomiting, fast pulse rate and contraction of pupils. Codeine comes under the jurisdiction of the Harrison Narcotic Law.

DIPHENHYDRAMINE HYDROCHLORIDE N.N.R.

(Antihistaminic)

PROPRIETARY NAMES: Benadryl Hydrochloride

PHARMACOLOGY: Diphenhydramine Hydrochloride, an antihistaminic drug, was first introduced in 1945. On the basis of laboratory evidence, it is thought to alleviate bronchial constriction in histaminic or anaphylactic shock, counteract vasodepressor effects of histamine and relieve smooth muscle spasm. Clinically it has been judged therapeutically effective in urticaria, angioneurotic edema, serum sickness and penicillin, streptomycin and sulfonamide reactions. Benadryl has been on clinical trial as a means of aborting the cold and alleviating cold symptoms on the assumption that the cold is an allergic response. The success of Benadryl and other antihistaminic drugs in combating the cold has been reported by John M. Brewster, Captain (MC) U.S.N., who has conducted extensive investigations along these lines.

DOSAGE: Average dosage is 50 mg. three or four times daily; in severe cases of allergy as much as 0.3 or 0.4 Gm. may be administered. It is available in 25 mg. capsules, 50 mg. Kapseals and in an elixir containing 10 mg. per 4 cc. The regimen followed in the Brewster study was 50 mg., repeated at four-hour intervals for at least three doses or more if cold symptoms persisted.

UNTOWARD ACTIONS: Sleepiness is the usual side effect although dizziness, weakness, dryness of mouth, nausea, nervousness, hyper-irritability have also been reported. Benzedrine or Dexedrine may be given to combat sedative effect.

Marjorie Parsons,
American Red Cross

NURSES ENERGIZE Blood Program

● THE EXTRAORDINARY SUCCESS of the wartime blood program of the American Red Cross and the public's vigorous support of all Red Cross activities for more than sixty years have combined to create confidence in the ARC's peacetime venture—a national network of blood centers.

Tentative plans for organizing a blood program of such magnitude were first considered in the autumn of 1946 after consultation with representatives of numerous national organizations and agencies concerned with the nation's health. By the end of September, 1949, the American National Red Cross Blood Program had completed 21 months of operation. On that date, 30 regional programs, including the all-mobile operation in Massachusetts, were functioning in hundreds of communities throughout the country. In the first 21 months of operation, blood had been collected in about 1,100 communities and distributed to more than 1,360 hospitals.*

Because of the extensive preliminary study, the mission of the National Blood Program crystallized into three general types of operation. It arranged for blood collection, including recruitment of volunteer donors, and the processing and distribution of blood to meet normal

*Some of our large cities, such as Seattle, San Francisco, Denver, South Bend, Dallas and others, consider themselves well-supplied with a sufficient number of blood banks and have not requested the ARC program.

peacetime needs for whole blood among the civilian and military population, served by the regional programs conducted by Red Cross chapters. The program also insured that its resources might be effectively drawn upon in time of a national emergency or disaster, and provided for the greatest utilization of therapeutic substances in whole blood.

In the National Blood Program, blood is collected at regional centers usually located in larger communities where there is a need for the service. Official approval by the county medical society, the local health department and the local hospital association or individual hospitals concerned, is required before the program is established through the Red Cross chapter.*

The chapters, which form a network throughout the country, operate these centers in close cooperation with the local medical societies, health agencies and hospitals, for it is from the centers that blood is supplied to hospitals and clinics for the physicians' use in the care of the ill and the injured. An indispensable part of the program, the Mobile Units, which operate from regional centers, provide for blood collection in industrial plants and other suitable public or private buildings in both urban and rural communities.

Members of the Blood and Blood Derivatives Committee of the ARC Advisory Board on Health Services, some of the country's foremost authorities in the field of blood, lay down the professional and technical standards to be followed in the program. This committee stimulates and guides research and investigation to insure the safety of the products made available by the National Blood Program and helps to determine how these products may be used for the greatest benefit to the public. The most effective methods for blood collecting, processing, storing and distributing are constantly being evaluated in order that the highest standards of operation and technique will be maintained.

by Doris Rhea, R.N.
Assistant Director of Nursing,
National Blood Program

Assisting in the accomplishment of the program's objectives is the graduate registered nurse who plays a vital role, particularly in the actual blood collection procedures and activities which relate to the well-being of the donor. Nurses constitute the largest single professional group of employes in the Blood Program, and the nature of their responsibilities under the direction of the physician warrants detailed preparation.

The chief nurse of each regional center, assisted by one or two deputies and a sufficient number of staff nurses, is responsible for the nursing activities in the center and in Mobile Unit operations. Primarily, these activities are concerned with the welfare and protection of the donor as well as the recipient, and include the recording of medical histories; blood pressure readings and hemoglobin

*No longer is there open opposition by certain medical societies to the ARC's new National Blood Program; time and accomplishment have proved its worth.

estimation tests; blood withdrawal or venepuncture; central supply room procedures; training and supervision of volunteers assigned to technical or semi-technical nursing duties. All nurses share actively in the public relations aspect of this health program, utilizing their full knowledge of public health and community organization to interpret the local program and promote its long-range objectives.

Orientation and training courses for Blood Program nurses have been conducted by the Red Cross since the program went into effect. In each of the ARC's four geographical areas, a nurse is responsible for the training and professional direction of all Blood Program nursing activities and personnel in the various centers within her area's jurisdiction. As new regional centers are prepared for activation, the nursing staffs are brought into the area headquarters for a two-week orientation and training course.

This comprehensive course is planned to meet the particular needs of the nurses and includes the actual demonstration and practice of the various nursing skills which are adaptable to classroom facilities. It is recognized that nurses need to be expert in the techniques of blood withdrawal and to have a wide knowledge of blood, its uses and its proper handling, but emphasis is also given throughout the course to the public relations responsibilities of the professional staff. Principles and methods of teaching, applicable to the Blood Program, are carefully reviewed; practice teaching assignments have become an integral part of the training program. Physician instructors conduct special sessions on hematology, the uses of blood and blood derivatives, principles in care of the donor and donor criteria, proper handling of blood and other procedures relating to the medical phases of the program. Carefully selected library resources in the field of blood are available to the trainees for additional study at assigned periods during the course. The Red Cross Standard First Aid Course is also given to the nursing group during its stay at the area office. By the time the nurse has completed the initial two weeks of the training program, she has had a broad introduction to the Red Cross, the Blood Program and the place she will assume in this health service.

Classroom experience is followed by a two-week assignment to an operating center where technical training and experience are provided under the careful supervision of skilled staff members. During this period, the nurse observes the organization and services of the Red Cross, particularly the function of the Regional Blood Program and its related activities on the community level. Centers utilized for this special "in-service" training offer an excellent opportunity for the new nurse to perfect the necessary nursing skills and to familiarize herself with the Blood Program on a practical basis.

Actual experience on a Mobile Unit operation at an industrial plant,

institution or in a rural community, is also provided the nurse trainee. In this way she can see the required facilities, the method of packing and transporting equipment, and the close cooperation of the participating chapter with the regional center. Special conferences with the chief nurse and other center personnel conclude the training assignment. Through these contacts the nurse may evaluate her training, clarify any questions, and make final preparation for her return to the center in which she is employed.

Nurses from many professional fields have entered the Red Cross Blood Program. To the majority of them, the nursing skills, public relations aspects, community health organization, teaching and related activities are not new. For others, almost complete training in community organization, Blood Program nursing activities and related responsibilities has been necessary. The training program, therefore, has remained flexible and can be readily adapted to meet the needs of the individual nurse.

As the program moves forward, it is anticipated that further plans will be made to coordinate training efforts. In some instances, the course may be conducted in chapters where the regional center is to be established. Special training for volunteer nurses and other chapter volunteers participating in the regional programs is now provided both in the regional center and cooperating chapters. Visual aids, training films, technical procedure manuals and other teaching tools are being developed to enrich the training course and enhance the value of the nursing program in general.

The National Blood Program offers a broad type of nursing experience because of its close relationship to hospital, donor and community. In turn, the nurse's professional training and interest directly further the progress of this vital health program. There is full understanding that the program must grow with experience, that some phases may be temporary, and that it is a long-range undertaking. Many changes in procedures and techniques may be necessary to attain perfection. Time, constant vigilance and cooperative effort will be required before its benefits can be assured on a nationwide basis.

Mental Hygiene Aspects of Nursing

● NURSES have an opportunity and a responsibility to aid in the prevention of mental illness, according to Miss Ruth Gilbert, R.N., assistant professor, Division of Nursing Education, Columbia University. To do so, they must learn how a normal personality develops, what the deviations from the normal are, and how social changes come about. More information on psychosomatic medicine should also be made available to nurses.

An *Open Letter* to Jane Doe, R.N.

● DO YOU MIND a lay person having a word with you about your profession? Perhaps you will not, seeing that so recently a lady with so much in skills, learning and experience has developed a rather remarkable study about the nursing profession and has also made some equally remarkable suggestions. I just want to ask you a few questions and get your reactions to all that is happening.

I've been reading the report of this study and many other articles about nursing. In recent conferences and conventions I have seen to it that the meetings on nursing had the doubtful honor of my presence. As a matter of fact, if the amount of spoken or written words is any criterion, yours has become of late one of the most important professions in the country.

In this welter of words and suggestions I have become confused. I realize, too, that by and large you are too busy to read all that is being written about your job. As in many other conferences, the panels on nursing care and the speeches about your place in the hospital are arranged by some very fine people who are no longer general duty nurses. I guess you can't be spared to attend these conferences—and even if you did, you perhaps may be too tired to rise to the point of feeling really intelligent and putting in your own two cents' worth.

What with this famous Report and some other suggestions from the medical profession and from skilled administrators as well, there have come to my mind some questions that I'd like you to straighten out.

I gather that there are going to be nearly a dozen different levels of people who are to care for the sick in hospitals. Do you object if I list them?

Professional Nurse with Degree
Graduate Nurse, R.N.
Licensed Practical Nurse
Student Nurse
Nursing Clerk
Nurse's Aide
Ward Maid
Orderly
Surgery Aide
Obstetrical Aide
Tray Girl

By the time we have multiplied these groups by three to allow for the

by Harold A. Zealley, Superintendent, Salem City (Ohio) Hospital Association

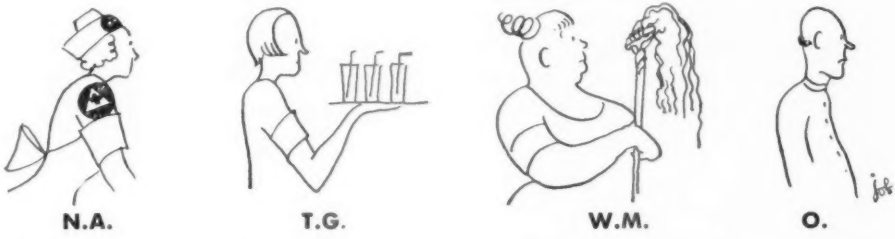
eight-hour shifts, there are 33 persons having something to do with our patient. Add to these the ministrations of our x-ray technicians, laboratory people, the physical therapist, and the occasional visits of the director of nurses and the superintendent, we can understand the whimsical complaint of a patient just recently: "Who is really looking after me? I have counted 30 different persons in the last 24 hours who have come into my room to do something for me!"

All this reminds me of my history book. Do you remember reading about the Industrial Revolution and Division of Labor? Out of that came Mass Production, which made possible a much higher standard of living because so many things could be produced at much less cost.

Maybe this is a minor Industrial Revolution in nursing, Division of Labor in the nursing department so that your job as nurse is divided up into all its varying categories and graded according to the skills required.

Look back at my list. In a recent article by an M.D. administrator he suggested that the prerequisite for the last six jobs in the list was an 8th grade education, and the amount of time that the 8th graders would relieve you of tasks considered unnecessary for you was from 70 to 80 per cent; some hospitals already have 80 per cent of your job being done by these groups.

Now I realize that in chronic disease hospitals and in some specialized institutions or departments, this may not have the same implications. But in most general hospitals, patients are, for the most part, pretty sick people. For many reasons, directly they are able to be moved, they are immediately discharged from our care.



In your training did they not say something about the vital use of the knowledge you were gaining—that the carrying of a pitcher of water to the bedside had more in it than giving a drink to a thirsty patient? You were trained in observation, and your glance at the patient had far more possibility of value than just the glass of water. Did they not teach that your training in physiology and anatomy has real values even as you do the daily chore of making the bed for a [*Continued on page* 51]

THE WONDER BEAN

by Lynne Svec

● YOUR BREAKFAST "crunchies," a glass of beer, Johnny's infant food, varnish, glue, candy, lipstick, a delectable diet for young mink, streptomycin nutrient, and perhaps a new hope for arthritis victims, all seemingly as far apart as the poles, have something in common: *soybeans* are back of each of these diversified products.

Sherlock Holmes himself would have had difficulty unraveling the many intricate and mysterious offshoots of this legume that looks like a pea and crunches like a peanut.

Actually, the soybean is not a bean. It has nothing to do with the ordinary bean, but no one has yet found a better name for it. It contains approximately 40 per cent protein — twice as much as ordinary beans. Its protein is the only known vegetable protein which has full biological value; that is, it can be used instead of meat, eggs and milk. The soybean contains approximately 20 per cent oil, while the ordinary bean has practically none.

Orientals, who live on an inexpensive vegetable diet, depend on the soybean — fresh, dried or fermented—to supplement rice and to supply them with a variety of dishes in place of milk, meat and eggs.

How did the soybean become China's "staff of life"? The answer is lost in the mists of time but legend has it that in the dim past of China, a caravan laden with gold, silver and valuable furs, while yet several days' journey from its destination in Eastern China, was set upon by bandits and took refuge in a rocky defile where defense was simplified. After a long siege, the traders were faced with starvation, when a servant pointed out dense growths of pod-bearing vines. Beans from the pods were pounded into coarse flour, mixed with water and made into rough cakes, which sufficed as food until the bandits left.

It took the soybean thousands of years to get from prehistoric China—where its cultivation was first recorded in the third century B. C.—to the United States where it was first introduced in the 1800's.

The story of the soybean is in large part the story of soybean processors, typified by A. E. Staley Manufacturing Company, the oldest soybean processor in the nation, whose Decatur, Illinois plant has become the soybean capital of the world.

In 1873 A. E. Staley, then a young boy, was given a handful of soy-

beans, presented to his father by a missionary just returned from China. He promptly planted them in the family garden. These are believed to have been the first soybeans planted in this country.

Years later, during World War I, when farm productivity had declined because of successive plantings of corn, Mr. Staley remembered how valuable soybeans had been in post-Civil War days in building up soil through use in crop rotation. So he and his representatives began touring the Midwest urging farmers to begin soybean planting and offering them a market for the beans.

Today, farmers by the hundreds of thousands grow soybeans; industrial workers by the scores of thousands depend upon them for their livelihood.

The first sizeable market for soybean products came in soybean oilmeal for cattle and poultry, and soybeans are currently the source of over 64 per cent of all oilmeal proteins fed in producing the nation's livestock. The next step in soybean development was the result of years of scientific study and experimentation in refining soybean oil for use in food and industrial fields. Today, 53 per cent of the total fats and oils used in making shortening and 44 per cent of all fats and oils used in making margarines are soybean oil.

During World War II, the soybean played a major part in the U.S. war effort. It supplied edible oils to replace those cut off by the seizure of the Philippines and East Indies; it supplied protein concentrates which made possible record-breaking production of meat, milk, eggs, cheese and poultry; it was the source of high-protein food not only for our fighting men but also the folks at home.

The steady increase in the civilian consumption of soy products, accelerated by the war, has been continued. The wide market for soy food products is indicated by the fact that 36 different types of soy products are made by 73 companies.

Meat packers sometimes use the soybean to increase the protein value of sausage, meat loaves and other similar [*Continued on page* 53]

Reviewing the News

► CHRISTMAS SEALS showing the photograph of Clara Maass, the nurse who sacrificed her life in a yellow fever experiment in Havana, are being distributed by her training school, now called the Lutheran Memorial Hospital in Newark, N.J.

► A SPIRIT OF HARMONY pervaded the New Jersey State Nurses' 47th annual convention held at Asbury Park October 19-21 and attended by approximately 900 nurses, lay members, guests and students. Business was handled with dispatch. Members approved a budgetary allowance for an active public relations program; a recommendation to the New Jersey Board of Nursing to raise the renewal license fee from $1 to $2; and the introduction of a $5 service charge for non-ANA members receiving counseling and placement benefits. Newly-elected officers were E. Elizabeth Brown, who was re-elected president; Margaret Maskrey, vice president; and Sarah Stevenson, treasurer. Betty Ruth Wood of the Mercer Hospital, Trenton, received the state's Linda Richards Achievement Award. Visitors from the national scene included Pearl McIver, ANA president; Lucile Petry, assistant surgeon general USPHS, who spoke on estimating the nursing needs of the nation; and Helen C. Goodale of the National Committee for the Improvement of Nursing Services. Miss Goodale, whose subject was "As I See the Brown Study Today," admitted that nursing leaders were eager for a new look in nursing, but emphasized that the "look" most becoming to the nurse would continue to be her uniform and cap rather than the collegiate gown and mortarboard.

► A NATIONWIDE SURVEY of blood bank resources is being conducted by a special AMA committee in an effort to determine the capacity, equipment, personnel, inventory, processing procedures and arrangements for emergency cooperation among the banks. Questionnaires have been sent to more than 1,500 blood banks and 5,100 hospitals without blood banks.

► ENTHUSIASTIC SUPPORT for the first Tri-State Regional Conference, sponsored by the New Jersey Industrial Nurses Association, the New York Industrial Nurses Club and the Philadelphia Nurses Association, was shown by more than two hundred industrial nurses and guests who gathered in Newark in October. Among the speakers were Dr. John J. Wittmer, vice president and medical director of the Consolidated Edison Company, N.Y., who stressed the integration of medical work and personnel work in industry and the nurse's place in management; and Mrs. Mary E. Delehanty, president of the AAIN, who discussed eco-

nomic security for nurses in industry, explaining the Association's opposition to collective bargaining for industrial nurses. Plans are now going forward for the 1950 Tri-State Conference which is to be held in New York City.

▶ STRONG OPPOSITION to the federal bill including aid to nursing education by some southern Representatives, nurses and doctors, especially Dr. James W. Davis of North Carolina, blocked attempts to pass the bill before Congress adjourned. Difficulty centered on the section of the bill designating professional bodies recognized by the USPHS Surgeon General as the agencies responsible for determining schools' professional qualifications for subsidy. Despite a last-minute compromise amendment giving the accrediting responsibility for nursing schools to state nursing licensing bodies, the bill failed to move to the House floor for vote.

▶ ABOUT PEOPLE: *L. M. Dalgleish,* head nurse at Margaret Hague Maternity Hospital, Jersey City, N.J., has received the Associated Royal Red Cross Medal, 2nd Class, a medal issued by command of King George VI. The citation accompanying the award praises the efficient work of Miss Dalgleish in the Canadian Army in World War II and her care of wounded troops in the face of danger . . . Three graduating seniors in the School of Nursing, University of California, *Dolores B. Newman, Hilda R. Posehn* and *Laura L. Ryan,* have been elected to membership in Phi Beta Kappa . . . New nurse appointees to the Nursing Service of the Red Cross National Blood Program are *Irene Berger Lucas,* technical supervisor, Eastern Area; *Avis Axelson,* active reserve nurse, Pacific Area; and *Hazel Abraham,* active reserve nurse, Southeastern Area . . . New assistant editors at the *American Journal of Nursing* are *Esther Brooks* (University of California School of Nursing) M.A., Teachers College, Columbia, and *Ruth T. McGrorey* (Meyer Memorial Hospital) M.A., Teachers College, Columbia . . . *Anna Taylor Howard,* who resigned her position as associate editor of the *AJN,* is making her home at Yellow Springs, Ohio where her husband has been appointed vice-president of Antioch College. Mrs. Howard is in the process of revising her textbook on ward teaching . . . *Marian G. Randall,* Executive Director of the Visiting Nurse Service of New York, has been elected one of the vice-presidents of the Board of Directors of Hospital Council of Greater New York.

▶ THE LARGEST GATHERING of public health workers ever held in the world [*Continued on page* 59]

An Open Letter

[*Continued from page* 45]

patient with a fracture? Again, that your removal of the bedpan might enable you to spot something that could be of untold value to the pathologist or diagnostician? That your training in dietetics would enable you to glance over the tray as you carried it from the bedside and perhaps discover worthwhile information for the physician? That your knowledge of psychology and a smattering of sociology might enable you to use your own resources as well as those of the hospital to make a patient feel secure in his new strange surroundings?

So may I ask my first question: If these tasks, and many similar ones that have the label "menial," are to be done by those who do not have your training and skill, was some of your precious time wasted in the past? Personally, I never thought it was, but have I to change my mind?

Perhaps the suggestion that "nurses are too well educated" made in another recent article is true. Or is it? Is the statement at a conference last month that "America cannot afford a well educated nurse" a valid one?

Then I see another problem. From 60 to 80 per cent of bedside nursing is to be done—by whom? Out of a welter of struggles, battles with legislatures, insistence on minimum standards, there has arisen, among others, at least one great value: standardization of ability and technique so that "R.N." in New York means basically the same thing in San Francisco, Chicago or Denver.

What is going to be the standard of care in our hospitals with these changes? All these nonprofessional people must have professional supervision, that is recognized. But what kind of standardization is going to be applied to those who ought to be supervised? To what extent are they to be supervised? Who is to determine what they can do without direct supervision, and when shall this be determined?

To return to the matter of division of labor, which is, of course, economically sound when we are dealing with materials, but is it sound, economically or otherwise, when dealing with sick people? It would take some years of training in automobile engineering for one man to manufacture an automobile from front bumper to rear light. But division of labor and complicated machinery have brought the amount of training necessary for each individual process down to a minimum.

No doubt it is for economic reasons, but we perhaps accept the fact that the suggestions regarding a more extensive division of labor in the nursing field have the same basic cause. It is an accepted fact that hospital patients cannot afford to pay for some nursing services at the hourly rates now being commanded by the graduate nurse. Also accepted are the statements that hospital deficits are not being met by private philanthropy as in days gone by and that greater percentages of hospital expenses are being charged directly

to the patients as a result. So in order to minimize these charges to the greatest extent, we frankly have to accept the fact that much of the care formerly rendered by the professional nurse is now to be done by individuals with less education in medical fields and less understanding of the implications of the illness of the patient.

We Have Two Alternatives

If this is to be the outcome of all these suggestions, is the argument illogical that we are faced with two alternatives: (1) that Nursing Care will deteriorate in quality; (2) if it does not deteriorate, then many of the demands, prerequisite qualifications, hours of study and work for student nurses over the years have been unnecessary, and in respect to the actual bedside care of the patient, not worth the effort? To put it a little more bluntly, do you really subscribe to the point of view that a person with an 8th grade education plus three or four months of on-the-job training can do from 60 to 80 per cent of the nursing in a hospital?

A carefully groomed figure in white, with the dainty white cap that, once in a while, has seemed like a halo to some grateful patient, has meant only one thing in the eyes of the average American—a nurse, one who, according to Webster, "cares for the sick and infirm." But with these new trends and suggestions fulfilled, will the actual "care" be passed on to some other person, and will your position in the hospital be that of a medical technician and supervisor? With the exception of responsibility for seeing that much of the service rendered by personnel with inferior training is done properly, medication preparation, administration and a little immediate postoperative care, most of the tasks performed for the patient are being passed on.

That you will be an important person I do not doubt. That you will command even a higher remuneration is quite possible. But will you any longer be a "nurse"? I wonder whether you will be as satisfied.

[Since *Modern Hospital*, in which this article originally appeared [October, 1949] has a limited nurse readership, the editors of **R.N.** requested permission to reprint it, believing that this viewpoint of a hospital administrator will be of interest to all nurses. We welcome your comments.—THE EDITORS.]

The Wonder Bean

[*Continued from page* 47]

products. It also prevents candy from drying out rapidly and gives added flavor to pastry and doughnuts. It is mixed with other flour to increase the protein content of bakery goods, macaroni and spaghetti.

There are soybean "milks" or "food whips." One soy milk is a special preparation for those who suffer from allergic reactions to animal milk. Soybean products are used in meat sauces, breakfast foods, ice cream, bouillon, prepared infant foods, and in brewing beer.

Although its industrial uses are comparatively few, it does appear in liquid soap, paint and varnish, linoleum and oilcloth, printing inks, lubricants and greases, furniture oils and polishes, and finishes for leather. It finds use in the manufacture of penicillin as well as window-pane envelopes.

Most unusual, perhaps, of all products from soybeans is the patented nutrient which makes possible the mass production of streptomycin, the miraculous antibiotic. The nutrient, which looks like soy flour, markedly stimulates the growth of the organism which excretes streptomycin. A bit more than two fifths of a pound, about four cents' worth, of soybean meal nutrient is used in making two million units of streptomycin, an average daily dosage given in six to eight injections. A bushel of soybeans is used in making sufficient nutrient to produce about 228 million units, approximately one-half pound of streptomycin—although the production per pound of nutrient used varies according to different manufacturing conditions.

This remarkable new use for soybeans was not without its headaches, however. At a time when the pharmaceutical industry was about convinced that soybean nutrient provided a solution for the problem of increasing production of streptomycin, there occurred the mystery of the vanishing mold. Several pharmaceutical firms reported that in the middle of the process of making streptomycin in huge tanks the mold would disappear over-night. The mystery was solved by first checking in research laboratories to see

whether there was anything in the meal itself which was detrimental to the mold. The nutrient was quickly absolved of blame and careful checks were made before the drug manufacturers uncovered the culprit—a virus which had crept into the mixture and which, when the process had progressed to a certain point, developed sufficient power to overcome and destroy the valuable mold. With a change in the manufacturing method, the problem of the disappearing mold was whipped.

Perhaps the most exciting news about the little wonder bean is its potentialities as a therapeutic measure for arthritis. A new Compound S, produced by Dr. Percy L. Julian, director of research in the soya products division of the Glidden Company of Cleveland and Chicago, may be an inexpensive substitute for Cortisone. Dr. Julian says the new compound is "chemically analogous" to Cortisone, lacking only one oxygen atom in its molecular substance. It is believed that the missing atom can be supplied by the human body.

Thus, with continued research and increased production, this versatile little pellet, the soybean, daily gives more promise of greater things to come.

In olden times walnuts were used as a medication for diseases of the brain. Ancients believed that since the shell was shaped somewhat like the human skull and the meat shaped like the brain, the contents of the walnut should be beneficial to sufferers of mental disease.

Candid Comments

[*Continued from page* 32]

in any way obscure sterility of thought. And in regard to techniques I'm inclined to agree with Theodore Roosevelt who is quoted as saying, "When I want to say something, the English language does not stand in my way." Get the idea down in any form, then let the techniques take over—but *capture the idea first.*

Three basic rules govern my own efforts: First, to have something to say; second, to use the waste basket prodigiously until I can say it understandably; and third, to work everlastingly to achieve simplicity. Every phrase of Lincoln's Gettysburg Address stands out like a gem yet he used mostly one and two syllable words, and only 267 of them.

Nurses do not have to hunt for things to say. Our days are packed with the drama for which novelists would give their arms. Our profession is packed with challenge and movement and problems that give us almost too much to speak and write about. Nurses have a goodly share of abilities and discernment necessary for good expression. Then, what are we waiting for? Why are we so undeveloped in the art of communication?

Sometimes nursing and religion went hand in hand. The 470 priestesses in the service of the Babylonian Temple of El Kumak about 700 B.C. were also nurses, visiting the city's sick, attending the injured, and even accompanying troops to battle.

Nursing Pointers

[*Continued from page* 33]

medicines yourself. The pharmacist is the person legally responsible for the label, and should you make a labeling mistake, you're sticking your professional neck out. However, if it's necessary to change a drug from its original container to another, always note the prescription number and carefully copy it on the new container. That prescription number is very important for reference. Copy, also, the patient's name, the doctor's name, that of the drug plus pertinent directions and carefully affix the label to the new container.

▶ Pay strict attention to a label. If it says "Shake Well Before Using," it means exactly that. It may be dangerous if you give a supernatant liquid for a period of time and then dispense a potent precipitate for the last few doses.

▶ Be extremely careful with narcotics. Keep them out of reach of a patient, his family and visitors. Don't label them as "narcotics" or mark sedatives and hypnotics as "sleeping pills."

▶ Handle all poisonous drugs with extreme care. Mark them "poison" in big letters; an amateur scrawl of a skull and crossbones is not enough. But, never allow a patient to see the word "poison" on a drug or place the drug within his reach, for you might be minus a depressed patient or two. Employ added safety measures: Put poisons in bottles of easily distinguishable shape or surface, or wrap a strip of adhesive around the bottle above the label or over the bottle cap. These measures will identify it as a dangerous poison should you pick it up in the dark. It goes without saying that you should be familiar with the effects of the poisons and their antidotes.

▶ In home duty, make it a practice not to have the prescription's formula written on the label. It's a good idea not to have the patient or his family know too much about the medication ordered for this is apt to lead to misunderstandings.

▶ The old rule of three in giving medications is always good. Read the label when you reach for the bottle, check it again when you pour the medication, and again when you put the drug back on the shelf. If you do all that it may take extra time, but it's well worth it. Better be safe than sorry!

[**R.N.** *welcomes articles or pointers on time-saving devices and special nursing techniques, that will be of interest to its readers.*]

A handy pamphlet "Nutrition Reference for Nurses," that can be tucked into nurses' bags, will be distributed by the New York State Department of Health to every public health nurse in the state. Nurses in other fields, whose minds go blank when asked the sources of vitamin B_1, might benefit from this concise round-up of food facts. It includes recommended daily dietary allowances and the description, functions and sources of carbohydrate, fat, protein, minerals and vitamins.

Canned Foods as a Source of Niacin
(NICOTINIC ACID)

Number 5 in a series which summarizes the conclusion about canned foods reached by authorities in nutrition research

Niacin is that member of the vitamin B complex which was formerly known as the "pellagra-preventive" or "P-P" factor. It is a normal constituent of all cells and functions as a component of enzymes in both glycolysis and respiration. (1)

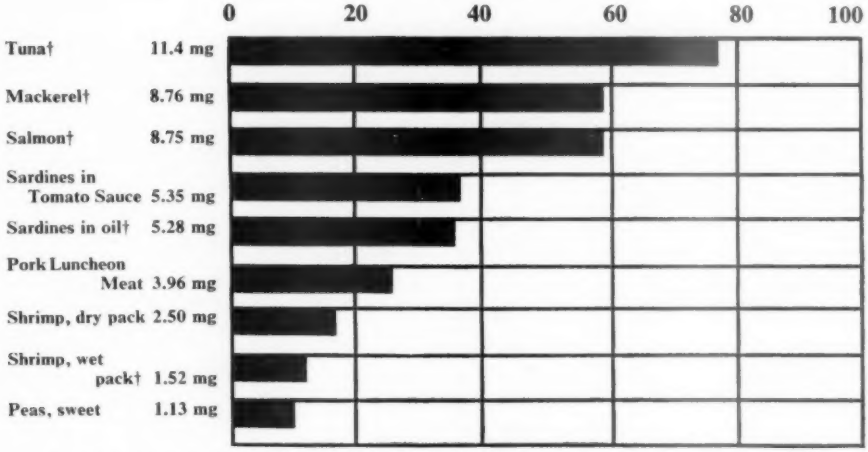
Deficiency of niacin manifests itself in skin lesions, inflammation of mucous membranes, respiration disturbances and when extreme, leads to symptoms of florid pellagra. Typical pellagra, however, may be the result of a multiple nutritional deficiency and is treated by the administration of not only niacin, but other members of the vitamin B complex, particularly riboflavin and thiamin. (2) A diet rich in proteins containing tryptophane is usually recommended. (3)

Meat, fish, cereal and legumes are the best sources of niacin. These foods contain the nutrient in relatively large amounts and the daily allowance can be obtained from a serving of several of them.

Niacin is heat stable so there is a good retention of the nutrient during the canning process. A number of commercially canned foods, in particular canned fish, meat, and legumes are important sources of niacin. (4)

Percentage of Recommended Daily Allowance* in 4-oz. (113 grams) Serving (4)

(Based on analysis of the entire can contents)



†*Brine or oil discarded.* **Percentage based on recommended daily allowance for physically active male—15 mg.—National Research Council.*

(1) 1943. *Handbook of Nutrition.* A. M. A. Council on Foods and Nutrition. Page 220. American Medical Association, Chicago.

(2) 1945. *Chemistry and Physiology of the Vitamins.* H. R. Rosenberg. Page 246. Interscience, New York.

(3) *Proc. Soc. Exp. Biol. Med.* **70**, 569-571 (1949).

(4) 1947. *The Canned Food Reference Manual.* American Can Company. Adapted from pages 251-252. New York.

CANCO **AMERICAN CAN COMPANY** • **230 Park Avenue, New York 17, N. Y.**

News

[*Continued from page* 49]

and one of the most extensive professional meetings of any kind to take place in New York City marked the 77th annual meeting of the American Public Health Association in October. Founded in 1872, the Association is the professional society of more than 11,000 men and women in public health work in the U.S., Canada, Mexico and Cuba. This year's extensive program consisted of 82 sessions devoted to workshops, round tables, panel discussions and the presentation of 224 papers. High point of the program was the granting of the awards donated annually by the Albert and Mary Lasker Foundation to both groups and individuals for outstanding achievements in medicine and public health. A special Lasker award, not given every year, was bestowed on Dr. Haven Emerson, past president of the APHA, noted author and public health authority, for extraordinary achievement in developing a program of local health services. Of special interest to nurses was the award granted to Marion W. Sheahan, the first non-doctor recipient, for "distinguished leadership in the fields of nursing and public health." Miss Sheahan, now executive director of the National Committee for the Improvement of Nursing Services, has in her 28 years of nursing served in various public health capacities in New York State, finally becoming director of the Division of Public Health Nursing in the New York State Department of Health. She was president of the NOPHN from 1944 to 1946 and in 1944 was named vice-president of the APHA. Other Lasker awards honored Dr. Andre Cournand for his work in cardiac catheterization; Dr. Max Theiler for his research leading to the production of effective yellow fever vaccines; Dr. William S. Tillett and Dr. L. R. Christensen for discoveries of two enzymes which make it possible to liquefy collections of blood, pus and necrotic tissue; and Dr. Philip S. Hench and Dr. E. C. Kendall for their studies of adrenal hormones which culminated in the dramatic therapeutic effect of Cortisone in rheumatic disorders. Group awards went to the American Academy of Pediatrics for its recent nationwide survey that revealed deficiencies in child-health services and pediatric education, and to the Life Insurance Medical Research Fund, a joint enterprise of life insurance companies of the U.S. and Canada, for providing financial support to basic medical research in cardiovascular diseases.

▶ MORE BENEFITS for veterans, their dependents and beneficiaries are provided by Public Law 339 which becomes effective December, 1949. Among those who receive additional compensation are all World War II veterans with service-connected disabilities, veterans with dependents rated 50 per cent or more disabled, World War I veterans with either "presumed" or directly service-connected disabilities, veterans

with arrested cases of tuberculosis and wartime widows with one or more children.

▶ RED CROSS ACTIVITIES: Plans for an accelerated program of nursing services include instructor-training courses for all home nursing instructors, intensive training of qualified nurses for disaster duty, and teaching of nurse's aides to serve public and private health agencies as well as hospitals. Home nursing instruction will now be given in two courses instead of five and special efforts will be made to reach ready-made groups such as are found in schools and housing projects, civic organizations, industrial workers and their families . . . Because of the depleted staffs of hospitals on Indian reservations in several western states, the Red Cross, at the request of the Bureau of Indian Affairs and by agreement with the Civil Service Commission, has launched a campaign to recruit 50 nurses for three months' emergency duty. Nurses interested in such an assignment are urged to contact their local Red Cross chapters immediately.

▶ VETERANS carrying National Service Life Insurance are advised to check the expiration date of their policies. For example, a nurse who might have purchased insurance in 1941 will find the current term period expiring by the end of this year. Application for conversion or renewal of the policy for an additional five-year period is permitted before the expiration date.

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Safer for clothes . . .

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Fireworks

[*Continued from page* 37]

After several days and many sessions have passed, even the most conscientious delegate becomes weary and tends to let things slip by without due deliberation. This is especially true of the inevitable last afternoon, when business needing action is piled up and delegates have trains and planes to catch. The members back home often wonder why certain action was taken or certain viewpoints omitted. The weary delegates, faced with a full agenda and a ticking clock, may rush through questions which, presented earlier in the meeting, might have been given much more thoughtful deliberation.

This last New York State Nurses Association meeting in Buffalo is a case in point. Of its three major discussions, two had general participation in the thinking and the discussion, while the third would probably have benefited from earlier and more thorough consideration.

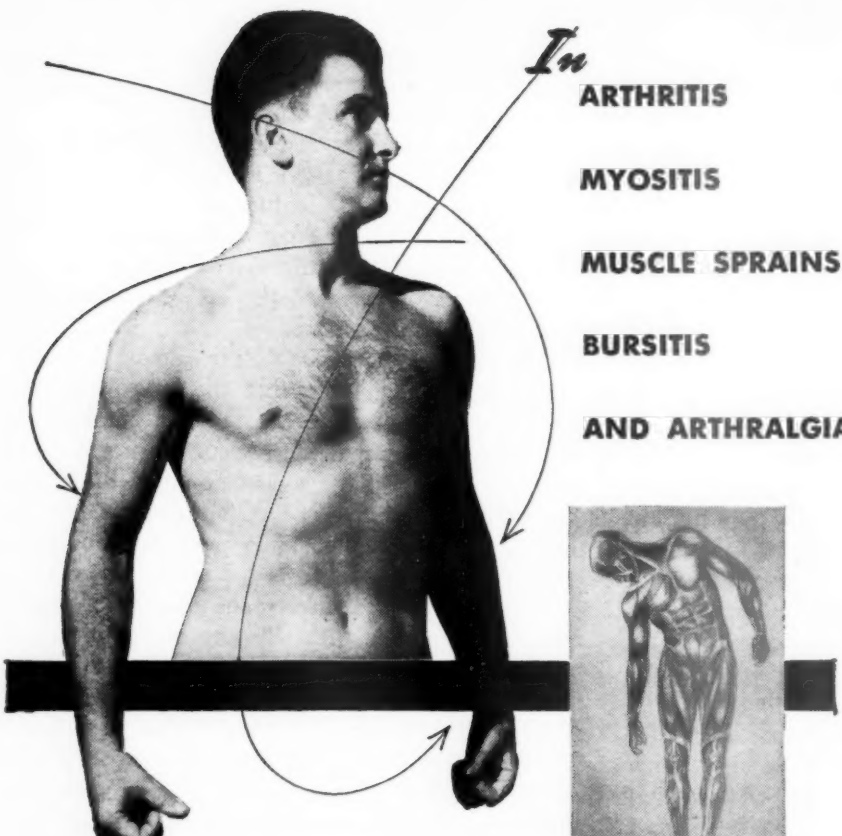
The first important stand of the delegate body was to align itself with the American Medical Association as opposing compulsory health insurance. The significant factor in the amended wording of the motion was not merely to go on record as *supporting* the doctors' opinion but to have the NYSNA itself take the stand, "Resolved that the New York State nurses as citizens and as the delegate body at this meeting oppose the proposed socialized or compulsory medical care plan." Therefore, the nurses of New York State aligned themselves with the allied profession of medicine as partners, not merely as an echo of the AMA's opinion.

The question of New York State's participation in the collective bargaining feature of the Economic Security Program, as outlined in the ANA platform, took the major part of three of the six scheduled business sessions.

It became clear, almost from the beginning, that the entire membership agreed upon the desirability of an economic security program for the state association but there was a difference of opinion on how to implement this program. Collective bargaining is *not economic security* but is merely one method of implementation. By the same token, an economic security program is not dependent upon the collective bargaining technique to be effective.

It gradually became apparent that there was a good deal of confusion and misunderstanding on the subject of what was meant by "economic security." It was agreed that the state association should undertake a vigorous educational program to acquaint the membership with the meaning, aims and objectives of the term before the next state biennial meeting in 1951.

As opinions began to crystallize, the underlying fear of being classed as a labor union, under an amended charter which would permit the state to engage in collective bargaining, took definite form. Various delegates expressed it differently, but



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the questions addressed to the Association's labor expert, attorney Robert H. Jones, III, slanted more and more toward this point. Arguments were often heated and each of the four floor microphones had a group of delegates waiting in line for their turn to be recognized.

Each speaker, without exception, expressed interest in promoting the welfare of nurses, but they questioned the means of attaining this objective. Over and over the delegates reiterated that if there were the slightest risk of being classed as nonprofessional, collective bargaining should not be considered. Loss of professional status was too high a price to pay.

The final vote showed that by a good margin the majority did not want New York State to engage in collective bargaining. This was reaffirmed when all reference to collective bargaining terminology was removed in amending the wording of the new charter. Because the articles of incorporation were amended from the floor, ratification necessitated a two-thirds majority vote.

As the changes in the charter did not reach the floor for discussion until the first part of the last session, the delegates faced the last two hours of scheduled business with the recommended changes in by-laws still awaiting action and several other matters of business still to be brought up. A sense of weariness, overlaid with haste, pervaded the atmosphere when the vital and important question of national structure for nursing organizations came before the house.

Several delegates who had come prepared to present arguments for one or for two organizations stated their views, but there was little discussion on the floor. Frankly, the delegates as a whole seemed apathetic. It was not a *lack* of interest, but rather as if they were beyond interest to take part in another prolonged discussion. It could very well be that the discussion and vote to support the one organization plan would have been arrived at eventually after due deliberation, but it seems unfortunate that it was voted for with so little discussion and so quickly.

In two years NYSNA will meet again in convention. Delegates will come from all parts of the state to listen, discuss and vote upon the vital problems concerning the nursing profession. By the democratic process they will arrive at their decisions. It is to be hoped that some method can be worked out to transact the overwhelming amount of business before extreme fatigue and weariness produces mental inertia.

A physician at sea made great use of sea water among his patients. Whatever ailed them, down must go a dose of this nauseating stuff. Came the day the doctor fell overboard. Great excitement ensued, in the midst of which the captain arrived and inquired, "What's the trouble?"

"Nothing," dryly answered a sailor, "only, the doctor has fallen into his medicine chest."

The Cold War

[*Continued from page* 36]

by means of sprays. The ideal nose drops should be non-irritating and not interfere with the ciliary movement which helps to eliminate bacteria; its *p*H should also be within the normal range of the nasal secretions. Even if these qualifications are met, one should go easy on nose drops, for too frequent application may result in secondary irritation or rebound congestion. The use of drops containing mineral oil may lead to lipid pneumonia. Even in a cold, self-medication may be dangerous, so it's better to consult your doctor.

Another popular pastime of the cold victim, gargling, has been proved of little therapeutic use, although frequently it may soothe and help clear the throat. Experiments with dyes have shown that the gargling liquid does not penetrate farther than the third molar tooth. However, a hot saline mixture may do some good in pharyngitis if it is applied with a douche or syringe.

Aspirin, while providing symptomatic relief in headache, fever and muscle pain, *is not a cold cure*, and may mask cold symptoms so that the patient is encouraged to do more than he should. Aspirin is also used in gargles, gum and troches for its anesthetic action in a sore throat. Respiratory sedatives or expectorants should be prescribed by the physician for the individual case. Penicillin by inhalation has been claimed to be of value in a cold but sulfa drugs and penicillin, while effective against many bacterial infections, have not shown overwhelming therapeutic effectiveness against the cold *per se*. Excessive use in common colds may make bacteria penicillin- or sulfa-resistant, thus invalidating the drugs' therapeutic value if more serious complications or diseases should occur.

A fairly new concept of the cold now undergoing considerable publicity is that the cold in its initial phase is an allergic reaction. One of the most important studies on this subject was done by John M. Brewster, Captain (MC) U.S.N., who concluded that antihistaminic drugs, by interrupting the allergic reaction,

were capable of "aborting the common cold when treatment is begun in the initial phase."* In the study he classified the cold as aborted or cured when all signs and symptoms disappeared within 24 hours after treatment was begun and did not reappear for at least 48 hours after stopping treatment. The following excerpt from his report shows some of his findings:

"All symptoms were aborted in 19 (90 per cent) of the 21 patients in whom treatment with antihistaminic drugs was begun within the first hour after the onset of symptoms and in 48 (87 per cent) of 55 patients treated within 2 hours of onset. One hundred and sixteen (74 per cent) of 156 patients who received treatment within 6 hours, and 165 (70 per cent) of 234 patients who received treatment within 12 hours of onset were also cured.

"A total of 77 patients were used as controls. The first five were given 32 milligrams of phenobarbital every 4 hours for 3 doses. However, when all complained of marked drowsiness and that it failed to relieve any of their symptoms, its use was discontinued. The combination of codeine sulfate with papaverine hydrochloride was then adopted as the control medication. Within 1 hour after onset of symptoms a cure was obtained in one of the two patients to whom this combination was given. Cure was obtained in 5 (42 per cent) of 12 patients who received treatment within 6 hours, and in 7 (31 per cent) of 22 patients in whom treatment was begun within 12 hours. In none in which therapy was begun more than 24 hours after onset was a cure obtained."*

These antihistaminic drugs also, when used as palliative treatment, shortened the period of morbidity and eliminated complications. Antihistaminics employed were Pyribenzamine, Thenylene, Neoantergan, Histadyl and Benadryl.

Several of the antihistaminics, which originally required a prescription because of their inclusion under the new drug section of the Federal Food and Drug Administration, can now, after being approved by this agency, be sold without a prescription. Although a few of these drugs are being publicized with the same fervency that attended the appearance of the ammoniated dentifrices, more scientific evidence will have to be developed before they can be

*U.S. Naval Medical Bulletin, Jan.-Feb., 1949, p. 9.

*Ibid, p. 4.

definitely proved to cure colds. Some medical authorities are maintaining a "watch and see" attitude, for cold cures have been discovered before and found wanting.

One of the antihistaminic drugs is described in this month's *Drug Digest*, together with three other drugs that have become established in the treatment of colds. It must be emphasized here that the latter are merely selections from a number of drugs designed to alleviate cold symptoms. Since a cold is always prescribed for on an individual basis, the doctor will be in the best position to judge just what *your* cold needs.

Perhaps in the future we'll be rid of the cold and its dangerous sequelae through the discovery of a cure. Maybe the antihistaminic drugs are part of the answer. But until the "perhaps" and "maybes" have been eliminated, it's a good idea to wear rubbers on rainy days, avoid drafts, stay away from crowded places as much as possible and lead a generally healthy life. And don't be one of those moist martyrs who say hoarsely, "I really shouldn't be here today, I have a dreadful cold." Stay home and tend to your Kleenex. Other people will get along without you and you may be saving yourself or someone else a month-long bout of pneumonia.

The hot water bottle, in the form of a bladder filled with hot water, was used to relieve pain 2,000 years ago, according to writings of the ancient Greek physician, Rufus.

R.N. Speaks

[*Continued from page* 25]

budget, efforts, and publicity going into this expensive Economic Security Program.

Many of us sincerely believe that we can never achieve even partial economic security, regardless of what means we use, until we put an equal amount of stress on the provision of good nursing care; in fact, we believe emphasis on this point is the one essential in providing the other. Unless we fight the battle of good nursing care—our only reason for existence—as worthily and intently as we fight the battle for a better economic break for nurses, our gains can, in the end, only become losses.

Every group has a spiritual as well as materialistic problem. The problem before nursing today is spiritual as well as materialistic. The words "economic security" must have both meanings to nurses or we will stand in danger of "gaining the whole world and losing our soul."

—Alice R. Clarke, R.N., Editor

The Comanche County (Kansas) chapter of the Red Cross, realizing the importance of having well-qualified nurses on call, has awarded two $500 scholarships to prospective student nurses from the county. The two applicants chosen by merit have agreed that after graduation they will work at least one year, at the regular rate of payment, in the county's new hospital.

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ANESTHETIST: One of the most modern of hospitals in Hawaii, delightful location. Transportation reimbursed after two years' service. RN 12-4 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ANESTHETISTS: 2. General hospital, 400 beds. Active surgery. Minimum. $300, complete maintenance. Middle West metropolis. RN 12-3 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ANESTHETISTS: (a) 200 bed approved Iowa hospital. $4800 yearly. (b) 80 bed general hospital near Denver. $4200. (c) New 100 bed modern hospital. $4800. Southwest. Woodward Medical Bureau, 185 North Wabash Ave., Chicago, Ill.

ASSISTANT: Assistant director of nursing service. Teaching hospital, delightful location. Completely furnished private suite provided in beautiful new apartment building. Middle West. RN 12-5 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ASSISTANT DIRECTOR OF NURSING: (a) 150 bed approved hospital Chicago area. $275, maintenance. Degree. (b) 100 bed hospital western university town. $3000, maintenance, up. Opportunity for advancement. Woodward Medical Bureau, 185 North Wabash Avenue, Chicago, Ill.

CENTRAL SUPPLY SUPERVISOR: Newly-created position, new department, splendidly equipped. 250 bed hospital. Perferably someone qualified to establish policies, regulations. New England. RN 12-16 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

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DIRECTOR OF NURSES: Fairly large hospital, relatively new. Expansion program includes new nurses' home. Fashionable winter resort town, Florida. RN 12-6 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

DIRECTOR OF NURSING: (a) 200 bed approved hospital. $5000. South. Degree. (b) 300 bed new hospital, Ohio college town. $5000, up. Woodward Medical Bureau, 185 North Wabash Avenue, Chicago, Ill.

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GENERAL DUTY NURSES: Qualified to take responsibility in Surgery also. Starting salary Penna. Registration $2418.00 per year, less maintenance. Straight 8 hour shifts. Inquire Medical Director, Pennsylvania State T.B. Hospital, Cresson, Pa.

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GENERAL STAFF NURSES: 5 day, 40 hour week. Salary $220 per month for rotating day, evening and night duty. Additional $10 per month for permanent evening duty and $5 per month for permanent night duty. Salary raises based upon merit to a maximum of $250 per month. If desired, rooms provided at $20 per month. All University holidays with pay. 12 working days paid vacation yearly. Accumulative illness allowance 12 working days yearly. Positions available in operating rooms, surgical, medical, neuropsychiatric and tuberculosis nursing units. Write University Hospital, Ann Arbor, Mich.

INDUSTRIAL NURSE: Large company located in industrial area of Chicago's North Side. Should be willing to rotate shifts. RN 12-10 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

INSTRUCTOR IN COMMUNICABLE DISEASES: Degree required. Salary $2639 without maintenance. Write Supt. of Nurses, Charles V. Chapin Hospital, Providence, R.I.

NURSES: General Duty, Head and Supervisory Nurses in acute communicable, TB or general emergency hospitals. Public Health Nurses and Public Health Nurses in Training. Salaries from $2876 to $4573. 40 hour week, no split shifts. Paid vacations, duty disability allowances, sick leaves, maternity leaves, pensions, death and sickness benefits. Apply Detroit Civil Service Commission, 735 Randolph Street, Detroit 26, Mich.

NURSING ARTS INSTRUCTORS: (a) 60 bed approved hospital western town of 10,000. $3600 yearly. (b) Assistant Instructor, 200 bed approved hospital, San Francisco. 5 day week, $270 monthly. Woodward Medical Bureau, 185 North Wabash Avenue, Chicago, Ill.

OBSTETRICAL SUPERVISOR: Hospital of medium size. Department of 26 beds and 18 bassinets. School has teaching affiliations. Fashionable winter resort town, Florida. RN 12-17 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

OBSTETRICAL SUPERVISORS: (a) 200 bed California Hospital. $270 per month. 5 day week. (b) 150 bed general hospital, Florida resort community. $2700 yearly. Woodward Medical Bureau, 185 North Wabash Avenue, Chicago, Ill.

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OPERATING ROOM SUPERVISOR: General hospital, 200 beds. One of the wealthiest cities in United States. University center. $300, maintenance. RN 12-18 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

OPERATING ROOM SUPERVISORS: (a) 200 bed general hospital western state capitol and resort. $3000 yearly. (b) 110 bed Florida hospital with college affiliations. $3000, maintenance. Woodward Medical Bureau, 185 North Wabash Avenue, Chicago, Ill.

PEDIATRIC SUPERVISOR: New pediatric hospital. Last word architecturally. College town, Middle West. Minimum, $4000. RN 12-19 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

PEDIATRIC SUPERVISORS: (a) 200 bed approved hospital Great Lakes Region. $3000 with annual increases. (b) 100 bed approved hospital. $3300 yearly, maintenance and paid annual vacation of one month. Woodward Medical Bureau, 185 North Wabash Avenue, Chicago, Ill.

PSYCHIATRIC SUPERVISORS: (2). Position open for day and night duty. Private approved 90 bed hospital near Cleveland. Salary with complete maintenance. 2 weeks' vacation, 7 holidays, sick leave. State salary expected. Apply Director, Windsor Hospital, Chagrin Falls, Ohio.

PUBLIC HEALTH NURSES: Position open for District Orthopedic Nurse with the Crippled Children's Division of Georgia State Department of Public Welfare. Requires one academic year of public health nursing and two years' experience. Orthopedic nursing desirable but not required. 5 day, 37 hour week. Generous paid vacation and sick leave. Good salary and travel allowance. Pleasant working conditions. Scholarships available. Apply Crippled Children's Division, 419 State Office Building, Atlanta, Ga.

[Turn the page]

PUBLIC HEALTH NURSES: Supervisor of nurses and also staff nurses. Generalized program. Salaries, respectively, $4200-$4800, $3300-$3720. County health department, California. RN 12-13 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

REGISTERED NURSE: 3-11. $210, meals. 15 bed hospital. Undergraduate nurse, $125, meals. Each nurse to supply own day relief as desired. Write Mrs. Hugh Gray, Cottage Hospital, Buffalo, Wyo.

REGISTERED NURSES: Several. General duty and supervising positions open. 40 bed private psychiatric hospital. Laundry and meals included. Beginning salary $200 per month. Psychiatric experience not necessary. Write full qualifications to Mrs. Ruth Sherman, McMillen Sanitarium, 840 N. Nelson Road, Columbus 3, Ohio.

REGISTERED NURSES: For 170-bed nonsectarian hospital with new 150-bed addition almost completed. Large interne resident program. Openings include operating room. Beginning salary $215 to $225. Meals may be purchased at low cost in cafeteria. Temporary rooms in residence while locating. Apply Director of Nurses, Mount Zion Hospital, San Francisco, Calif.

SCIENCE INSTRUCTOR: (a) 200 bed approved hospital southeastern college town. $3000, maintenance. (b) 100 bed Ohio hospital with college affiliations. 5 day week, $3000, maintenance. Woodward Medical Bureau, 185 North Wabash Avenue, Chicago, Ill.

STAFF NURSES: For modern 250 bed general hospital and 75 bed maternity hospital. Must be eligible for registration in California. Salary $210 monthly, plus 2 meals and laundry. Increases at six-month intervals. $10 additional for evening, night and maternity duty. $20 additional for surgery. 40 hour week. Housing available at nominal cost. Apply Superintendent of Nurses, Sutter Hospital, Sacramento, Calif.

STAFF NURSES: Relatively new hospital, one of the larger towns of Alaska, located on the coast. $215, complete maintenance. Transportation from Seattle refunded after year. RN 12-14 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

STAFF NURSES: Starting salary $2640 a year including maintenance. 8 hour day. Yearly increases to $3200. Liberal vacation and sick leave, pension plan. Pleasant living quarters. Maintenance charge $480 a year. Apply Supt. of Nurses, Essex County Sanatorium, Verona, N.J.

STAFF NURSES: 250 bed tuberculosis hospital. Salary to start $225, regular increases. 40 hour, 5 day week. Excellent living and working conditions. Complete maintenance if desired $30. Apply Director of Nursing Service. Tulare-Kings Tuberculosis Hospital, Springville, Cal. [Turn the page]

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STAFF NURSES: (a) 30 bed new hospital adjacent Caliente, Nevada. $230. (b) 20 bed new hospital, Alaska. $2400, maintenance. (c) 100 bed California tuberculosis hospital. $235 to start increasing to $275 plus maintenance. 40 hour week. Woodward Medical Bureau, 185 North Wabash Avenue, Chicago, Ill.

STUDENT HEALTH NURSE: Young women's college. Living accommodations on campus. Will have privilege of all campus facilities. East. RN 12-20 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SUPERVISORS AND STAFF NURSES: 40 hour week. All services. Good salary and working conditions. Housing accommodations in nearby communities. Must be registered in California. Apply Director of Nursing, Orange County Hospital, Orange, Calif.

SURGERY NURSES: For modern 250 bed general hospital. Salary $230, increases every 6 months. $10 additional for p.m. or night shift, plus 2 meals, laundry and complete prepaid medical insurance. 40 hour week. Liberal personnel policy. Housing available at nominal cost. Apply Superintendent of Nurses, Sutter Hospital, Sacramento, Calif.

SURGICAL NURSE: also general duty nurse: $200 and maintenance, 8 hour day, 5½ day week. Crossett Health Center, Crossett, Ark.

SURGICAL NURSES: (a) 100 bed approved hospital southern California. $2640 yearly. 40 hour week. (b) 200 bed general hospital San Francisco. $2800 yearly. 5 day week. Social Security benefits. Woodward Medical Bureau, 185 North Wabash Avenue, Chicago, Ill.

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Antihistaminic Therapy of the Common Cold

Nature of the Common Cold

Since the work of Kruse in Germany, and of Shibley and associates in this country, it has been generally accepted that the common cold is caused by a virus, as yet unidentified. Although no specific therapy has yet been discovered for the infective agent, investigators have noted a marked similarity between allergic symptoms and many of the symptoms of the cold. The report of Troescher-Elam and others that the nasal secretions of patients with colds contained twice as much histamine as was found in allergic rhinitis emphasized the allergic component of the common cold.

In an editorial in the J.A.M.A., September 10, 1949 on allergy in epidemiology of the common cold the view is expressed that cold-susceptible patients often present borderline or subclinical types of allergy. According to Fox and Livingston the common cold is actually an allergic response to the cold virus or its products.

The present-day concept of the phenomenon whereby latent pathogens located in the upper respiratory tract suddenly become the virulent secondary invaders of the common cold may be outlined as follows:

1 The cold virus comes in contact with the tissues of the upper respiratory tract.

2 An allergic reaction follows characterized by edema of the mucous membranes.

3 There may be an associated trigger mechanism such as chilling. ingestion of food to which one is sensitive, etc., which further stimulates the allergic reaction.

4 The edematous mucous membranes lose their normal protective powers and provide a better culture medium for the cold virus and other pathogens.

5 Further invasion of the body by pathogens may follow, causing the complications of the common cold.

Thus, it is readily seen that counteracting the allergic reaction can break the chain in this course of events.

The Role of Antihistaminics

In the September, 1947 issue of the United States Naval Medical Bulletin, Brewster reported that antihistaminic therapy in the common cold gave unusually satisfactory results. In a later series of 572 patients treated with any one of five different antihistaminics

results were obtained which confirmed this earlier impression. Similar findings were reported by Gordon on 500 cases of upper respiratory infection, and by Murray on 494 patients treated with antihistaminics.

These studies point out several important facts:

a that 70-90% of colds are aborted or alleviated with antihistaminic therapy;

b that the effectiveness of treatment depends on prompt institution of therapy;

c that antihistaminics are effective as a group;

d that the reduction of sneezing and coughing usually effected, regardless of the duration of the cold itself, reduces the spread of the common cold by eliminating droplet exposure.

Therapy

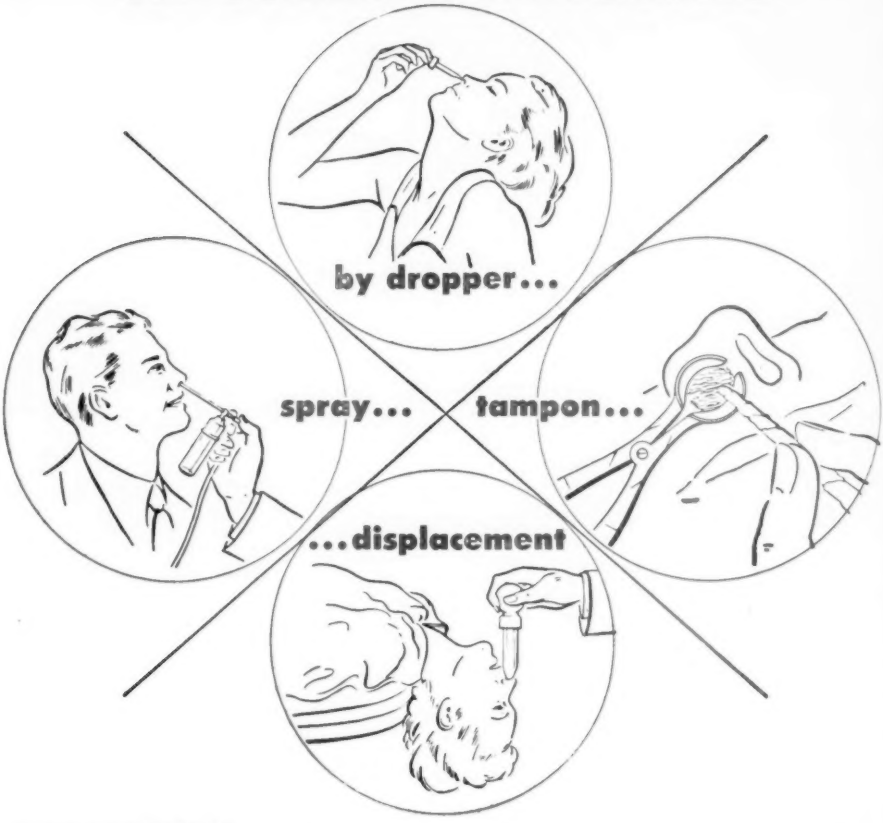
Inhiston is the potent antihistaminic 1-phenyl-1-(2-pyridyl)-3-dimethylaminopropane characterized by effectiveness of antihistaminic action and low incidence of undesirable side-effects. It has been proven in numerous clinical studies in a variety of clinical conditions. Medical literature has appeared based on comparative clinical studies stating that this particular compound is superior to some of the earlier preparations in effectiveness and absence of side-effects. Laboratory studies show that the therapeutic index — the ratio of potency to toxicity—of *Inhiston* is 135.* This compares most favorably with the ratios of potency to toxicity of widely used older antihistaminics which range from 48 to 70. Therefore, the maximum recommended daily dosage of *Inhiston* is only 60 mg. whereas the recommended dosage of most other antihistaminics must be 100 mg. or more, per day. *Inhiston's* lower effective dosage level is of real advantage since it further reduces the possibility of side-effects.

Inhiston, therefore, is a truly effective antihistaminic for control of the common cold. When taken at the first sign of a cold it can abort the cold. Taken later, *Inhiston* helps shorten the duration of the cold, reducing cross-infection by stopping excessive nasal secretion. Its availability without prescription indicates clinical safety and enables each individual to have it within reach at the very first sign of the common cold, the optimum time to commence antihistaminic therapy.

The *Inhiston* package is plainly and carefully labeled to emphasize when the drug should be taken and when discontinued, and how much should be taken. A separate dosage schedule is given for children, and specific warning is made in regard to possible drowsiness. Professional samples of *Inhiston* are available upon request.

Union Pharmaceutical Co., Montclair, N.J. *THERAPEUTIC INDEX = $\frac{LD_{50}}{ED_{50}}$

IN COLDS...SINUSITIS



neo-synephrine hydrochloride constricts the engorged mucosa surrounding the ostia, permitting free entrance of air and free drainage of secretions. Neo-Synephrine hydrochloride affords prompt and prolonged decongestion with virtually no irritation or congestive rebound.

neo-synephrine®

HYDROCHLORIDE

BRAND OF PHENYLEPHRINE HYDROCHLORIDE

¼% solution (plain and aromatic), 1 ounce bottles; 1% solution, 1 ounce bottles; ½% water soluble jelly, ⅝ ounce tubes.

Neo-Synephrine, trademark reg. U. S. & Canada

Winthrop-Stearns INC.

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